STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495113	A. BUILDING _____ B. WING _____	C 03/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIRAM W DAVIS MEDICAL CTR	26317 WEST WASHINGTON STREET PETERSBURG, VA 23803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 03/26/2019 through 03/28/2019. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 3-26-19 through 3-28-19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One complaint was investigated during the survey. The census in this 90 certified bed facility was 50 at the time of the survey. The survey sample consisted of 21 Resident reviews.	F 000		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services	F 582	1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.** The Utilization Review Committee will be educated on the use of SNFABN form CMS-10055 and their role related to its implementation. 2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice.** The necessary Facility staff will identify other residents having the potential to be affected by the same deficient practice by conducting a 100% audit of all residents currently receiving Medicare services.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Michelle Jones, LNHA | Facility Director | 4-12-19

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 582	Continued From page 1 specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation	F 582	3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.** A SNFABN form (CMS-10055) will be completed by the Billing/Reimbursement Office designee, for all residents receiving Medicare covered services and forwarded to the Utilization Review Coordinator. Once termination of coverage has been projected, the SNFABN form, along with the Notice of Medicare Non-Coverage (CMS-10123) will be presented/mailed to the beneficiary or his or her legal representative, to ensure timely notice to continue skilled care services and have Medicare make a determination of coverage in the case of appeal. 4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.** The Facility will monitor its performance with a bi-monthly audit to ensure that solutions are sustained by identifying projected endpoint of skilled care services and tracking that the SNFABN and NOMNC documentation has been completed and mailed timely. The audit results will be subject to monthly review by the QAPI committee. 5. **Include dates when the corrective action will be completed. (The "outside" date by which all corrections must be made is the 45th calendar day after the survey ended.)** Corrective action will be completed by May 4, 2019.	

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F 582	Continued From page 2 review and clinical record review, the facility staff failed to complete a SNF ABN (Skilled Nursing Facility Advance Beneficiary Notice) for 3 Residents (Resident #300, Resident #301, Resident #23) in a survey sample of 21 Residents. 1. For Resident #300, the facility staff failed to provide a SNF ABN notice prior to skilled care services, paid by Medicare, ended. Resident #300 was not afforded the opportunity to continue skilled care services and have Medicare make a determination about coverage of such services. 2. For Resident #301, the facility staff failed to provide a SNF ABN notice prior to skilled care services, paid by Medicare, ended. Resident #301 was not afforded the opportunity to continue skilled care services and have Medicare make a determination about coverage of such services. 3. For resident #23, the facility staff failed to provide a SNF ABN notice prior to skilled care services, paid by Medicare, ended. Resident #23 was not afforded the opportunity to continue skilled care services and have Medicare make a determination about coverage of such services. The findings included: 1. For Resident #300, the facility staff failed to provide a SNF ABN notice prior to skilled care services, paid by Medicare, ended. Resident #300 was not afforded the opportunity to continue skilled care services and have Medicare make a determination about coverage of such services. Resident #300, was admitted to the facility on	F 582		

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F 582	Continued From page 3 9/26/09, with a readmission date of 3/6/19. Resident #300's diagnoses included but were not limited to: neurogenic bladder, septicemia, cerebral palsy, seizure disorder, manic depression, and psychotic disorder. Resident #300's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 3/13/19 was coded as an Admission Assessment. Resident #300 was coded as his cognitive skills for daily decision making being severely impaired. The resident was also coded as being totally dependent upon two staff members for bed mobility, transfers, dressing, toileting and bathing. The resident was coded as being totally dependent upon one staff person for eating and personal hygiene. Resident #300 was discharged from a Medicare covered Part A stay on 3/22/19, he remained in the facility. Facility record review of Medicare discharge notices on 3/27/19, revealed the facility mailed a NOMNC (notice of medicare non-coverage) and letter dated 3/18/19 to Resident #300's family member stating that his Medicare covered Part A stay would end on 3/22/19. A copy of the certified mail receipt was attached. The Administrator was asked on 3/27/19 if any other documentation was available regarding the Medicare discharge notices. No further information was provided. On 03/27/19 at 04:03 PM during an interview with Employee I, Utilization Review Coordinator, she stated she is the responsible person for sending the notices and when asked about the notices	F 582		

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F 582	Continued From page 4 sent, she stated, "This is all that I send. We don't have any other form." The facility staff provided Resident #300 with the NOMNC, which provides notice of the right to an appeal and expedited review of service termination. The facility staff failed to provide Resident #300 with the second required notice, a SNF ABN, which allows the resident an option to continue to receive services, be notified of the expected cost, and have Medicare make the coverage determination once a bill is submitted to Medicare. The Administrator and DON, were informed on 3/27/19 at 4:44pm of the failure of staff to provide Resident #300 with a SNF ABN notice prior to skilled care services ending, which would have allowed Resident #300 or his representative, to make a decision about continuation of services and have Medicare make the coverage determination. No further information was provided. 2. For Resident #301, the facility staff failed to provide a SNF ABN notice prior to skilled care services, paid by Medicare, ended. Resident #301 was not afforded the opportunity to continue skilled care services and have Medicare make a determination about coverage of such services. Resident #301 was admitted to the facility on 11/02/18. The resident's diagnoses included but were not limited to, hip fracture, dementia, Parkinson's disease, malnutrition, anxiety and depression.	F 582		

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F 582	Continued From page 5 Resident #301's most recent MDS (Minimum Data Set) (an assessment tool) with an ARD (assessment reference date) of 11/19/18, was coded as a 14 day assessment. Resident #301 was coded as having a BIMS (Brief Interview for Mental Status) score of 11, indicating moderately impaired cognition. The resident was coded as requiring limited assistance of one staff member for activities of daily living except bathing, which the resident required extensive assistance. Resident #301 was discharged from a Medicare covered Part A stay, and from the facility on 11/19/18. Facility record review of Medicare discharge notices on 3/27/19, revealed the facility mailed a NOMNC (notice of medicare non-coverage) and letter dated 11/13/18 to Resident #301's family member stating that her Medicare covered Part A stay would end on 11/19/18. A copy of the certified mail receipt was attached and a signed return receipt card. The Administrator was asked on 3/27/19 if any other documentation was available regarding the Medicare discharge notices. No further information was provided. On 03/27/19 at 04:03 PM during an interview with Employee I, Utilization Review Coordinator, she stated she is the responsible person for sending the notices and when asked about the notices sent, she stated, "This is all that I send. We don't have any other form." The facility staff provided Resident #301 with the NOMNC, which provides notice of the right to an appeal and expedited review of service termination. The facility staff failed to provide Resident #301 with the second required notice, a	F 582		

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F 582	Continued From page 6 SNF ABN, which allows the resident an option to continue to receive services, be notified of the expected cost, and have Medicare make the coverage determination once a bill is submitted to Medicare. The Administrator and DON, were informed on 3/27/19 at 4:44pm of the failure of staff to provide Resident #301 with a SNF ABN notice prior to skilled care services ending, which would have allowed Resident #301 or her representative, to make a decision about continuation of services and have Medicare make the coverage determination. No further information was provided. 3. For Resident #23, the facility staff failed to provide a SNF ABN notice prior to skilled care services, paid by Medicare, ended. Resident #23 was not afforded the opportunity to continue skilled care services and have Medicare make a determination about coverage of such services. Resident #23, a 57 year old female, was admitted to the facility on 4/17/13. Her diagnosis included but were not limited to: quadriplegia, seizure disorder, profound intellectual disabilities, cyst of pancreas and GERD (gastro-esophageal reflux disease). Resident #23's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 1/21/19, was coded as the resident having severe cognitive impairment for daily decision making. The resident was coded as being totally dependent upon two staff persons for bed mobility, transfers,	F 582		

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F 582	Continued From page 7 toilet use and bathing. Resident #23 was discharged from a Medicare covered Part A stay on 1/25/19. Facility record review of Medicare discharge notices on 3/27/19, revealed the facility mailed a NOMNC (notice of medicare non-coverage) and letter dated 1/15/19 to Resident #23's family member stating that her Medicare covered Part A stay would end on 1/25/19. A copy of the certified mail being returned to sender as being undeliverable as addressed, was attached. The Administrator was asked on 3/27/19 if any other documentation was available regarding the Medicare discharge notices. No further information was provided. On 03/27/19 at 04:03 PM during an interview with Employee I, Utilization Review Coordinator, she stated she is the responsible person for sending the notices and when asked about the notices sent, she stated, "This is all that I send. We don't have any other form." The facility staff provided Resident #23 with the NOMNC, which provides notice of the right to an appeal and expedited review of service termination. The facility staff failed to provide Resident #23 with the second required notice, a SNF ABN, which allows the resident an option to continue to receive services, be notified of the expected cost, and have Medicare make the coverage determination once a bill is submitted to Medicare. The Administrator and DON, were informed on 3/27/19 at 4:44pm of the failure of staff to provide Resident #23 with a SNF ABN notice prior to	F 582		

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F 582	Continued From page 8 skilled care services ending, which would have allowed Resident #23 or her representative, to make a decision about continuation of services and have Medicare make the coverage determination. No further information was provided.	F 582		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility documentation the facility staff failed to implement their abuse and neglect policy. 1. For Resident #35 the facility staff failed to implement abuse and neglect policy for an injury of unknown origin. 2. For Resident #45, the facility staff failed to implement their policy and procedure of abuse for a fracture of unknown origin. The findings include:	F 607	1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.** Upon receiving the X-Ray report, resident #35's physician implemented a plan of treatment conducive with diagnosis of fracture of the knee. The radiology techs were also re-educated regarding the policy to treat each report of fracture as STAT report and notify the physician immediately. The facility did notify VDH and an investigation was started when the Facility Director was made aware of the results of the x-ray. The investigator for resident # 45 was made aware of the need for interviewing staff members for all investigations of abuse and neglect. 2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice.** All residents have the potential to be affected by the deficient practice of delaying notification of OLC and not interviewing staff. 3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.** A tracking log will be developed to ensure all components of investigations of abuse or neglect are completed and fully investigated within the time constraints required and that the investigator interviews potential staff members involved.	

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F 607	Continued From page 9 1. For Resident #35 the facility staff failed to implement abuse and neglect policy for an injury of unknown origin. Note: This deficiency is the result of an investigation conducted in relation to (Facility Related Incident) FRI send to the Office of Licensure and Certification on 11/3/2017. The FRI indicated that Resident #25 had X-Rays that showed a possible fracture of knee as a result of an injury of unknown origin. Resident #35 a 62 year old woman was admitted to the facility on 12/23/1993 with diagnoses of but not limited to Schizophrenia, Involuntary Commitment, G-Tube feeding, Impaired mobility, Bilateral hand contractures, Seizure Disorder, Dialysis Dependent, and depression. On 3/26/19 at 2:00 PM requested investigation for FRI that was sent to OLC. Administrator explained that previous employee responsible for investigations was no longer at facility and that she would try to find the investigation. On 3/27/19 a clinical record review was conducted and it was found that Resident #35 had complained of pain and showed signs of pain such as facial grimaces since 10/24/17. Her attending physician ordered X-Rays on November 2, 2017. According to documents provided by the facility Administrator the results were of the X-Rays were received by Radiology Dept. at the facility and date stamped on Nov. 2, 2017, however MD was not notified by Radiology until Nov. 3, 2017 thus creating a delay in notification to the Office of Licensure and Certification and a delay in	F 607	4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.** The Facility Director or designee will provide oversight of each investigation from start to finish to ensure compliance of abuse and neglect policy and required notification timeframes to OLC are adhered to. 5. **Include dates when the corrective action will be completed. (The "outside" date by which all corrections must be made is the 45th calendar day after the survey ended.)** The "outside" date by which all corrections will be made is the May 4, 2019.	

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F 607	Continued From page 10 treatment. A review of the Abuse and neglect policy provided by the facility page 3 Paragraph E states: E. All allegations of abuse/neglect and incidents of unknown origin (IUO) are reported to the Virginia Department of Health (VDH) in accordance with Centers of Medicare and Medicaid Services (CMS) conditions of Participation as follows: 1. Abuse / Neglect allegations will be reported within 2 hours of discovery. 2. Incident of unknown origin resulted in a serious injury to a patient/resident will be reported within two (2) hours of discovery. 3. Incidents of unknown origin resulting in no apparent injury or minor injury will be reported no later than two (2) hours of discovery. 4. A copy of the report that is faxed to VDH will be emailed to CNE Facility Director, Medical Director, Clinical Director and Risk Manager. The program would not be complete without a procedure for investigating allegations of abuse and neglect that do occasionally occur. Specially trained personnel, who while responding to an allegation, report directly to the Office of Investigations Management at DBHDS, investigate these allegations. The facility Director will maintain the products of these investigations. In an interview with the Administrator she stated that the Radiology dept. at the facility failed to notify the doctor of the results on the day it was received Nov 2, 2018. She further stated that the facility launched an	F 607		

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F 607	Continued From page 11 investigation and notified the VDH as soon as they had the results of the X-Rays. The Administrator and the Medical Director were made aware of the findings on 3/28/19 during the end of day meeting no further information was provided. 2. For Resident #45, the facility staff failed to implement their policy and procedure of abuse for a fracture of unknown origin. Resident #45, was admitted to the facility on 9/22/09. Diagnoses included but were not limited to: profound intellectual disability, Down's Syndrome with severe congenital hear disease, pulmonic stenosis, polycythemia secondary to chronic hypoxemia, chronic hypothyroidism, osteoporosis, Hepatitis B carrier, and self injurious behavior. Resident #45's most recent MDS (Minimum Data Set) (an assessment tool) with an ARD (assessment reference date) of 12/5/18 was coded as a quarterly assessment. Resident #45 was coded as having severe cognitive impairment. The resident was also coded as requiring limited assistance of two staff members for transfers, and being totally dependent on staff for dressing, toileting and bathing. Resident #45 required supervision of one staff member for eating. During clinical record review on 3/27/19 and 3/28/19, of the nursing notes, physician progress notes, nursing assessments and social worker notes there was no indication of an investigation.	F 607		

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F 607	Continued From page 12 Nursing notes read on 8/28/19 resident was "observed sitting up in w/c (wheel chair) @ (at) nursing station. Observed rubbing hard headphones against left shoulder area. Small purple bruise noted on left shoulder." Nursing notes dated 9/1/18 read, "noted to have 2 new parallel areas of bruising to left shoulder and left anterior chest. Fading bruising remains to top of left shoulder and anterior left chest skin intact." Nursing notes dated 9/5/18 read "bruise to l (left) shoulder spreading down to L (left) breast." Nursing notes dated 9/6/18 read, "bruising of left shoulder, chest, & lower side remains. Seems to be protective guarding of moving left arm." On 9/7/18 x-ray results revealed a "non-displaced acute fracture of distal clavicle." On 3/27/19 at 9am, the Administrator was requested to provide investigation information for Resident #45's injury. A blue folder was provided. The folder contained the following 10 documents. 1. Investigator's summary dated 9/12/18 2. FRI (Facility reported incident) report which was submitted to the office of licensure 3. A facility event report dated 8/28/18 4. Interdisciplinary notes dated 8/27/18-9/9/18 5. Physician interdisciplinary notes dated 8/8/18-9/10/14 6. Physician orders dated 9/5/18-9/10/18 7. X-ray reports dated 9/7/18 8. Fax confirmation of APS (Adult Protective Services) notification of injury 9. A Letter dated 9/13/18 addressed to Resident #45's guardian with a certified mail receipt and signed return receipt card which notified her an investigation was being performed 10. A letter dated 9/14/18 addressed to Resident #45's guardian which read, "based on the	F 607		

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F 607	Continued From page 13 preponderance of evidence, the case was found to be unsubstantiated for neglect and the case is now closed." The facility Administrator was asked again on 3/27/19 at 4:44pm and the morning of 3/28/19 to provide any additional investigation information regarding Resident #45. On 03/28/19 at 10:59 AM the Administrator said "there is nothing else." On 3/28/19 at 1:19pm a telephone call was made to Employee H, the investigator, and she stated "I looked through the chart at the documentation related to the issue." When asked if she interviewed any nursing staff, CNA staff, other residents, or radiology personal; she stated, "no ma'am." The resident was unable to be protected from further abuse, as the Administrator and the Director of Nursing stated no staff had been interviewed during the investigation of abuse and neglect for Resident #45. Review of the facility Policy and Procedure titled: "Patient Abuse, Neglect, & Injuries of Unknown Origin; Prevention & Investigation of" with a revision date of 3/4/19 states, the purpose of the policy is "To provide guidance to staff concerning the prevention of patient/resident abuse and/or neglect, and to establish uniform procedures for the reporting and investigation of allegations of patient/resident abuse, neglect, or injuries of an unknown origin." The policy reads: "All unexplained fractures are reportable as alleged abuse/neglect." "(facility name) has zero tolerance for acts of abuse or neglect. Therefore, whenever an allegation of abuse or neglect is made, (Facility name) shall take immediate steps to protect the safety & welfare of	F 607		

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F 607	Continued From page 14 patients/residents who may be victims of the alleged abuse or neglect, conduct a thorough investigation and take any action necessary to prevent future occurrences of abuse or neglect." The facility staff failed to implement their abuse policy in regard to investigating allegations of alleged abuse. The facility Administrator and Director of Nursing were made aware of these findings on 3/28/19 at 2:16pm. No additional information was provided.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	F 609	1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.** There were no noted effects suffered by resident #2 and #24 from the failure of a final summary report of injury of unknown origin (IUO) having not been sent to VDH within five working days. 2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice.** All residents have the potential to be affected by the deficient practice of failure to investigate IUOs. 3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.** An IUO checklist will be developed to track all incident reports of injury of unknown origin to ensure all components of IUO investigations are completed within the required timeframe and that the final report summary is submitted to VDH.	

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F 609	Continued From page 15 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility documentation review the facility staff failed to submit a 5 day follow up report to the State Agency for two residents (Resident #2 and #24) in a survey sample of 21 residents. 1. For Resident #2, the facility did not report the results of the investigation of an injury of unknown origin to the State Agency. Resident # 2 was found with a large raised area on the right side of her forehead on 9/29/18. 2. For Resident #24, the facility staff failed to report investigation results of an injury of unknown origin to the state agency. Resident #24 was found with bruising to her third and fifth fingers on her right hand. The findings included: 1. For Resident #2, the facility did not report the results of the investigation of an injury of unknown origin to the State Agency. Resident # 2 was found with a large raised area on the right side of her forehead on 9/29/18. Resident # 2, an 57 year old female, was admitted to the facility on 1/30/2017. Her diagnoses included but were not limited to:	F 609	4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.** The Facility Director or designee will provide oversight of each IUO from start to finish to ensure compliance with the regulation for completing an investigation for injuries of unknown origin. 5. **Include dates when the corrective action will be completed. (The "outside" date by which all corrections must be made is the 45th calendar day after the survey ended.)** The "outside" date by which all corrections will be made is May 4, 2019.	

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F 609	Continued From page 16 Profound Intellectual Disability, ITP (Idiopathic Thrombocytopenic Purpura)(low levels of blood cells that prevent bleeding), Dysphagia, Reactive Airway Disease, Seizure Disorder and Aspiration Syndrome. The most recent Minimum Data Set assessment was a Quarterly assessment with an assessment reference date (ARD) of 3/12/19. Resident # 2 was coded as having severe cognitive impairment. Resident # 2 was coded as requiring total assistance of one staff person for Activities of Daily Living except she required total assistance of two staff persons for bathing and transfers. Resident # 2 was coded as always incontinent of bowel and bladder. Review of the clinical record was conducted on 3/27/2019. Review of the Interdisciplinary notes (nurses notes) revealed documentation of: 9/29/2018 at 8:00 AM ....."0540 (5:40 AM) noted up in chair, has large raised area on right side of forehead [sic], no bleeding, sm (small) amt (amount) of bruising center of area, ice pack applied, helped some, swelling decreased some, chg (charge) nurse aware, doctor notified. will see pt (patient) on rounds. 9/29/2018 at 1400 (2:00 PM) Patient was up in wheelchair at start of dayshift. Patient noted with a 7 cm (centimeter) x 7 cm raised intact area of swelling and bruising to right forehead.....Pt seen by Dr. _____(Employee G) on morning rounds. No new orders received. Review of the Physicians Interdisciplinary Notes	F 609		

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F 609	Continued From page 17 revealed documentation on 9/29/2018 11:02 AM- c/c (complaint/ concern): right forehead bump-wound swelling and bruised. No neurological deficit, well localized bump with intact skin. Diagnosis: bump on right forehead. (May be related to bang herself.) Prescription: (1) close observation (2) incident report (3) called left message on answering machine for family 10/1/2018 at 1400 (2:00 PM) c/c: forehead bruise-fading but spread to right temple/face bump decrease Diagnosis: right forehead bump- still continuous, purposeless, wide Rx (prescription) observation On 3/27/2019 at 9:18 AM, an interview was conducted with doctor (Employee F) who stated she was Resident # 2's doctor and was told of the injury of unknown origin when she returned to work. Employee F stated another doctor (Employee G) was on call that day. Employee F was informed the surveyor would complete the interview with her after interviewing Employee G. On 3/27/2019 at 9:24 AM, an interview was conducted with the doctor (Employee G) who was on call on 9/29/2018 when the injury of unknown origin was discovered. Employee G stated he was informed of the injury and assessed Resident # 2 when he made rounds. Employee G stated he discovered swelling and a bruise. Employee G stated the lump was a good size and appeared to be hit by something probably in the morning hours. Employee G stated the injury was	F 609		

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F 609	Continued From page 18 unwitnessed, an ice pack was applied along with close observation. Employee G stated due to Resident # 2's history of low platelets disease (ITP) any banging or any injuries would cause lots of bruising. On 3/27/2019 at 9:29 AM, a subsequent interview was conducted with Resident # 2's primary doctor (Employee F) who stated Resident # 2 had involuntary movements of her head and that it was possible that she hit her head on the side rails. Employee F stated it was more likely possible that Resident # 2 sustained the injury of unknown origin during a transfer with the hoyer lift. Employee F stated the lump and bruise were indicative of a strong impact to the right side of her forehead. Employee F stated the facility staff have now begun to cradle Resident # 2's head during transfers to prevent her from bumping her head. On 3/27/2019 at 10:20 AM, an interview was conducted with the Director of Nursing (DON) who stated she had been informed by the nursing supervisor on the day the injury of unknown origin was discovered. The DON stated the investigation showed the injury probably happened during the transfer with the hoyer lift. The DON stated the nursing staff on all three shifts were educated on "transfer training". Six pages of sign in sheets of training on Transfer Training were presented. Review of the Training Signature Record revealed that training was conducted on various dates and shifts and included Certified Nursing Assistant, Licensed Practical Nurses and Registered Nurses.	F 609		

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F 609	Continued From page 19 Review of the facility's investigation report revealed no documentation of the summary of the investigation of the injury of unknown origin being reported to the State Agency. There was an email written on 9/29/2018 by the Director of Nursing to the former risk manager informing him of the injury of unknown origin for Resident # 2. The email stated "We have a VDH reportable on IUO for ___(Resident # 2) and would like to report it to you. Please follow up with me on Monday. Report put in ____box." Further review of the facility documentation of the investigation revealed a document that the Administrator stated was the final report submitted to her by the former Risk Manager. The document stated: "Aide related to RN (Registered Nurse) that they observed an about 8 cm (centimeter) 'bump' on resident's right forehead. Area assessed; skin intact, swelling viable and skin reddish in color.. Action Taken: ice pack wrapped in washcloth applied. AR(Authorized Representative)/Family, MD (Medical Doctor), Nurse and Supervisor notified; resident seen by Nurse at time of discovery (0600)(6:00 AM) and MD (1000)(10:00 AM) No new orders at the time of notification. Incident reported to VDH/CMS (Virginia Department of Health/Center for Medicare and Medicaid Services) as IUO (Injury of Unknown Origin); FD (Facility Director) and Advocate notified per report. Investigation initiated Sept. 29, 2018 per report. The report also stated: "Patient/Resident unable to respond to interview questions due to intellectual disability. Over the course of the investigation, Resident's aides at the time of	F 609		

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F 609	Continued From page 20 discover were interviewed. Both were unable to state how injury occurred but speculated that resident's behavior of moving head from side to side may have contributed to injury, possibly during a transfer using the Hoyer lift. The unit Manager and resident's nurse and aide were interviewed on Oct. 2, 2018, both noted a possible cause of injury the resident's uncontrolled head movements, trashing [sic] from side to side. The nurse manager also remarked on the resident's ITP (Idiopathic Thrombocytopenic Purpura), which allows for easy bruising and extreme bleeding..... There is no discernible pattern of occurrence of this incident to the resident or others on her unit. There is no evidence to support or abuse or neglect as a cause of the incident. The type and location of the injury is as previously reported. Resident care is properly addressed in her treatment plan. RM (Risk Management) Assessment: The reported facts and circumstances DO NOT meet the definition of suspicious injury. However, based on the review summarized above, this incident remains unresolved as to cause of injury. While injury is suspected to be accidental in nature, related to the resident's uncontrolled head movement, the actual cause of the injury was unwitnessed and remained unexplained. " On 3/27/2019 at 10:36 AM, an interview was conducted with the Administrator and Director of Nursing regarding the process regarding any injuries of unknown origin. The Administrator stated the facility investigates all injuries of unknown origin and completes a summary report within five days. The Administrator stated there	F 609		

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F 609	Continued From page 21 had been recent changes in Risk Management personnel and there was difficulty finding documentation of the summary of the investigation of Resident # 2's injury of unknown origin being sent to the State Agency. The Director of Nurses stated the facility's expectation was: the nurse would assess the resident for injuries, start neurological checks, notify the medical doctor, and responsible party. The nurse would start the investigation, notify the Director of Nursing, Administrator. The investigation would include interviewing resident if possible, interviewing staff, inspect to make sure the equipment is operating properly, putting appropriate interventions in place, and update care plans. The Administrator and DON stated the facility would report an injury to the State Agency and a summary of the investigation should be reported within 5 days to the State Agency. Review of the facility abuse policy "Patient Abuse, Neglect, & Injuries of Unknown Origin: Prevention, Investigation of: Effective date 3/10/2006, Revised Date: 3/4/2019" revealed "C. Injuries of Unknown or Unexplained Origin (IUO) are an indicator that patient/resident abuse/neglect has occurred. A patient/resident injury is considered to be a possible IUO if: 1. The injury's cause can not be reasonably determined. 2. When an incident report is received coding the report event as "Unexplained," 3. When an incident report is received without a marked event category.	F 609		

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F 609	Continued From page 22 Incident of unknown origin resulting in serious injury to a patient/resident must be reported to the Facility Director and Physician immediately, but no later than two (2) hours of discovery. All incident of unknown origin will be reported to VDH/CMS as follows: * Incident of unknown origin resulting in serious injury to a patient/resident will be reported within two (2) hours of discovery *Incidents of unknown origin resulting in no apparent injury or minor injury will be reported no later than two (2) hours of discovery All unknown patient/resident events must be explained if at all possible by: 1.. The supervisor initially receiving the report, 2. The Risk Manager during the initial review of the report, 3. The interdisciplinary treatment team after discussion at daily meetings. 4. By Physician or Nurse in the ID notes. All IUOs will be reported to: 1. The Facility Director 2. The Facility Advocate 3. The patent/resident's Authorized Representative (AR) 4. The Virginia Department of Health (VDH) Any investigation that leads to an allegation of patient/resident abuse/neglect must be reported to the Facility Director immediately. Investigation of the IUO must be completed within five (5) business days of the incident. Results must be reported to the Facility Director and the	F 609		

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F 609	Continued From page 23 Virginia Department of Health (VDH) within five (5) business days." On 3/28/19 at 2:00 PM, the Administrator and DON were again informed of the findings. The Administrator stated she did not find any documentation of the final summary being submitted to the State Agency of an injury of unknown origin for Resident # 2. No further information was provided. 2. For Resident #24, the facility staff failed to report investigation results of an injury of unknown origin to the state agency. Resident #24 was found with bruising to her third and fifth fingers on her right hand. Resident #24, an 80-year old female, was admitted to the facility on 02/11/2010. Diagnoses include but not limited to vascular dementia, impaired mobility, spastic contracture of hands, motor paralysis lower extremities, and seizure disorder. Resident #24's most recent Minimum Data Set (MDS) had an Assessment Reference Date (ARD) of 01/21/2019 and was coded as a quarterly assessment. Resident #24 was not coded for a Brief Interview of Mental Status (BIMS). Cognitive skills for daily decision-making were coded as severely impaired. Functional status for bed mobility, transfers, eating (tube feedings), dressing, and personal hygiene were all coded as total dependence on staff. On 10/26/2018 at 11:47 AM, a facility-reported incident (FRI) was transmitted to the state agency	F 609		

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F 609	Continued From page 24 in reference to Resident #24 and an injury of unknown origin. Under the section entitled 'Description of Incident', it was documented, "Around 0900 on 10-26-18, staff reported patient had discoloration to right 3rd and 5th fingers. Fifth right knuckle slightly swollen and purple in color. No break in skin." Under the section entitled 'Facility Action Taken', it was documented, "NP (nurse practitioner) in to assess patient. xray (sic) right hand (3rd-5th fingers) ordered. Ice to right hand 15 minutes every 4 hours x 24 hours." On 03/28/2019 at 10:00 AM, the Administrator stated that Employee H [employed by an outside agency] was the investigator for Resident #24's injury of unknown origin. A copy of the investigation documentation and a copy of facility investigation protocol was requested. On 03/28/2019 at 12:35 PM, the Administrator provided 2 pages of an email conversation between Employee C (clinical director) and Employee H (investigator). An email dated 10/29/18 at 1:52 PM documented, "Hi [Employee H]: Ecchymosis - causes breaking of the capillaries. She had taken Vitamin C to help with this but it was discontinued at some point. It's now been ordered again. Here are some samples of how we write it. The one labeled IUO is how I write it. The other is how [name] wrote it. Either way is fine ....please let me know if you have any questions. Thanks, [Employee C]." An email dated 10/30/18 at 10:28 AM documented, "Good morning [Employee C] I am currently working on the report for [Resident #24] and have a couple questions ...what is [MD name]'s title? Is he/she active in [Resident #24]'s treatment? How did he/she learn about [Resident	F 609		

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F 609	Continued From page 25 #24]'s injury? In other words, I'm trying to figure out how he ended up telling us about the ecchymosis ...Any info you can share would be helpful. [Employee H]." An email dated 10/30/18 at 11:05 AM documented, "Hi [Employee H], [MD name] is the Medical Director. So she's not on his direct caseload, but he oversees the care of all the pts (patients) and makes recommendations as needed. He's been here for years and is very familiar with her case. Hope that helps, [Employee C]." On 03/28/2019 at 12:45 PM, the Administrator provided "all the documentation" associated with the investigation which was seven pages. Included in the packet of papers: 1. Facsimile transmittal sheet dated 10/26/18 that was sent to the state agency on the day of incident 2. Facility Reported Incident Form dated 10/26/18 that was sent to state agency on the day of incident 3. A copy of the nurse's note dated 10/26/18 at 12:00 PM 4. A copy of the NP progress note dated 10/26/18 at 10:15 AM 5. A Facility Event Report dated 10/26/18 6. Handwritten notes by Employee H dated 10/26/18. 7. Typewritten report by Employee H dated 10/26/18 The Facility Event Report was a document with many boxes to select as relevant. The event date was 10/26/18. The event time was 9:50 AM. "Unexplained" was selected for "Type of Event." "Bedroom" was select for "Location." "Bruise" was selected for "Type of Injury." Under the section "Describe Event, it was documented, "Staff reported patient had discoloration to right 3rd and	F 609		

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	495113	A. BUILDING _____ B. WING _____	C 03/28/2019

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F 609	Continued From page 26 5th fingers. Fifth right digit knuckle slightly swollen and purple in color. No break in skin." Under the section "Treatment/Interventions", it was documented, "NP in to assess patient. New order to x-ray right hand/3rd-5th fingers discoloration to right 3-5th fingers. Ice to right hand 15 min every 4 hours x 24 hours." Nurse was notified on 10/26/18 at 9:55 AM. MD/NP notified 10/26/18 at 10:00 AM. Supervisor was notified 10/26/18 at 11:00 AM. The form was signed by the RN (registered nurse) completing the form. The copy of the handwritten notes by Employee H (investigator) was a lined paper that documented: "10/26/18 [Resident #24's last name] IUO [injury of unknown origin] No known injury/accident-nothing documented [name] - Mdirector Pt has ecchymosis - has had long time Vitamin C for symptoms. quit taking new order." On 03/28/2019 at 1:15 PM, a telephone interview with Employee H was conducted. Employee H verified that the notes listed above were her handwritten notes of the investigation. When asked about her investigation process, she stated that Resident #24 was not able to speak so she reviewed Resident #24's chart. When asked if she spoke with any of the staff or interviewed anyone in the course of her investigation, she stated, "No." The typewritten report by Employee H was dated 10/26/2018. Under the section "Description of Incident" it was documented, "Incident of	F 609		

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F 609	Continued From page 27 Unknown Origin: Resident was found with bruising to her right hand at approximately 0950 hours in the morning of Friday, 10/26/2018. Interdisciplinary notes from 10-26-18 written by [name] RN stated there was discoloration to right 3rd and 5th fingers with 5th right digit knuckle noted to be slightly swollen and purple in color. There was no break in skin, no active bleeding, no wincing or facial grimacing when palpating the fingers. At approximately 1015 hours, FNP (family nurse practitioner) [name] assessed [Resident #24] and an x-ray of her right hand (3rd and 5th fingers) was ordered. An order for ice to the right hand every 15 minutes every 4 hours for 24 hours was also made. Continue to monitor." Under the section "Facility Action Taken" it was documented, "Facility and Clinical Director were notified on Friday 10/26/2018 and an IUO (injury of unknown origin) investigation was initiated. [State and federal agencies] notified. Reviewed interdisciplinary notes and spoke with nursing staff and [MD name], facility medical director. As the medical director, [name] oversees the patients at [facility] and is very familiar with [Resident #24]. He stated the area appeared to be a result of ecchymosis. A condition [Resident #24] has had for quite some time and has taken vitamin C for in the past to aide (sic) with symptoms. A new order for vitamin C has been made. [Resident #24] has no documented symptoms of pain or distress from the injury. After further investigation, there are no new findings in this case." In summary, the state agency received initial facility-report incident documentation on 10/26/2018 pertaining to Resident #24 and her injury of unknown origin. The facility did not report	F 609		

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F 609	Continued From page 28 follow-up investigation results pertaining to Resident #24 and her injury of unknown origin. On 03/28/2019 at approximately 3:45 PM, the Administrator and the DON were notified of findings and they offered no further documentation of information.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interviews, clinical record review, and facility documentation, the facility staff failed to thoroughly investigate an injury of unknown origin for 2 residents (Resident #24, Resident #45) out of a sample size of 21 residents. The findings included:	F 610	1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.** There were no noted effects suffered from the failure to conduct a thorough injury of unknown origin (IUO) investigation for resident # 24 to ensure she was not a victim of abuse and failure to conduct an investigation for fracture of unknown origin for resident #45. 2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice.** All residents have the potential to be affected by the deficient practice of failure to investigate IUO. 3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.** An IUO checklist will be developed to track all incident reports of injury of unknown origin to ensure all components of IUO investigations are completed within the required timeframe and that the final report summary is submitted to VDH. 4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.** The Facility Director or designee will provide oversight of each IUO from start to finish to ensure compliance with the regulation for completing an investigation for injuries of unknown origin.	

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F 610	Continued From page 29 1. For Resident #24, the facility staff failed to fully investigate an injury of unknown origin to ensure Resident #24 was not a victim of abuse. Resident #24 was found with bruising to her third and fifth fingers on her right hand. 2. For Resident #45, the facility staff failed to conduct an investigation for a fracture of unknown origin. The findings include: Resident #24, an 80-year old female, was admitted to the facility on 02/11/2010. Diagnoses include but not limited to vascular dementia, impaired mobility, spastic contracture of hands, motor paralysis lower extremities, and seizure disorder. Resident #24's most recent Minimum Data Set (MDS) had an Assessment Reference Date (ARD) of 01/21/2019 and was coded as a quarterly assessment. Resident #24 was not coded for a Brief Interview of Mental Status (BIMS). Cognitive skills for daily decision-making were coded as severely impaired. Functional status for bed mobility, transfers, eating (tube feedings), dressing, and personal hygiene were all coded as total dependence on staff. On 10/26/2018 at 11:47 AM, a facility-reported incident (FRI) was transmitted to the state agency in reference to Resident #24 and an injury of unknown origin. Under the section entitled 'Description of Incident', it was documented, "Around 0900 on 10-26-18, staff reported patient had discoloration to right 3rd and 5th fingers. Fifth right knuckle slightly swollen and purple in color. No break in skin." Under the section entitled	F 610	5. **Include dates when the corrective action will be completed. (The "outside" date by which all corrections must be made is the 45th calendar day after the survey ended.)** The "outside" date by which all corrections will be made is May 4, 2019.	

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F 610	Continued From page 30 'Facility Action Taken', it was documented, "NP (nurse practitioner) in to assess patient. xray (sic) right hand (3rd-5th fingers) ordered. Ice to right hand 15 minutes every 4 hours x 24 hours." An NP progress note dated 10/26/18 at 10:15 AM documented, "Reported purplish discoloration on Rt (right) 3rd and 5th finger/knuckle area. No reported/known injury. Palm roll was off. Appears slightly swollen. X-ray will be ordered. Ice to area, monitor." Physician's orders dated 10/26/18 at 10:15 AM documented, "X-ray right hand (3rd-5th fingers) - discoloration to rt (right) 3-5th fingers. Ice to Rt hand 15 min every 4 hours x 24 hours." A nurse's note dated 10/26/18 at 12:00 PM documented, "Alert and responsive. Respirations even and unlabored. Staff reported patient had discoloration to write 3rd and 5th fingers. 5th right digit knuckle slightly swollen and purple in color. No breaks in skin. No active bleeding noted. No wincing or facial grimacing when palpating fingers. Fingers to right hand slightly contracted. Palm roll in place. 1000 VS (10:00 AM vital signs) 97.9 (temperature), 99 (pulse), 17 (respirations), 113 / 67 (blood pressure) O2 sat (oxygen saturation) 95% RA (room air). NP in to assess patient. New order to x-ray right hand 3rd through 5th fingers, discoloration to write three through five fingers. Ice to right hand 15 minutes Q (every) 4 hours x 24 hours." A radiographic report dated 10/26/2018 at 8:01 PM documented, "Impression: 1. no definite radiographic evidence of acute fracture or dislocation. If there are persistent symptoms, follow-up x-ray may be obtained as clinically	F 610		

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F 610	Continued From page 31	F 610		

warranted. 2. Old fracture first metacarpal healed with mild deformity. 3. Specifically, 3rd through 5th digits intact. 4. Moderate osteopenia or osteoporosis is demonstrated. 5. Mild degree of osteoarthritis."

A nurse's note dated 10/27/18 at 6:00 AM documented, "Ice to right hand x 2(every 4 hours) Knuckle next to thumb (index finger) slightly swollen and red to purple in color resp [respirations] even and unlabored skin warm and dry to touch Alert and responsive HOB [elevated] tolerating tube feeding In no acute distress"

A physician's order dated 10/29/18 at 9:45 AM documented, "Vit C 500 mg po [by mouth] daily (via G tube) [gastrostomy tube] daily x 30 days."

A physician's progress note dated 10/29/18 at 9:46 a.m. documented, "S [subjective]. Bruise noted on right hand last Friday Oct 26, 2018. X-ray of the hand - no fracture 0 [objective].Reddish discoloration noted over right hand, [illegible] 5th and 4th metacarpals and between 4th and 3rd metacarpals. The areas have prominent and engorged veins and capillaries with loose skin. [illegible] discoloration looks like ecchymosis from spontaneous rupture of various capillaries. A [assessment]. Ecchymosis, right hand P [plan]. Will add Vit C [vitamin C] to drug regimen."

A physician's progress note dated 10/29/18 at 10 a.m. documented, " bruise on right hand/ not knuckle."

On 03/28/2019, the DON explained that medication orders are renewed every 30 days and are considered active on the date the

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F 610	Continued From page 32	F 610		

physician signs the order. Physician's medication orders signed on 09/25/2018, 10/23/2018, and 11/19/2018 documented, "Multivitamin/Mineral LIQU [liquid] Take 15 ml [milliliters] daily via G-tube [gastrostomy tube]." A copy of the physician's order when the multivitamin was first initiated was requested. A copy of the multivitamin package insert was also requested. The facility staff provided a copy of a physician's order dated 03/25/2010 at 3:00 PM which documented, "MVI [multivitamin] with mineral supplement 15 ml [milliliters] GT [gastrostomy tube] x 30d [days]. Start first dose 03/26/2010." The facility staff also provided a copy of the "Supplement Facts" for the multivitamin that Resident #24 has been receiving since 2010. Included on the list of vitamins in the multivitamin was Vitamin C 60mg, 150% of the recommended daily value.

The Medication Administration Record (MAR) from 09/25/18 through 11/22/18 was reviewed. MVI was administered daily as ordered during that date range. Vitamin C was also administered daily from 10/29/18 through 11/22/18.

On 03/28/2019 at 10:00 AM, the Administrator stated that Employee H [employed by an outside agency] was the investigator for Resident #24's injury of unknown origin. A copy of the investigation documentation and a copy of facility investigation protocol was requested.

On 03/28/2019 at 12:35 PM, the Administrator provided 2 pages of an email conversation between Employee J (clinical director) and Employee H (investigator). An email dated 10/29/18 at 1:52 PM documented, "Hi [Employee H]: Ecchymosis - causes breaking of the capillaries. She had taken Vitamin C to help with

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F 610	Continued From page 33 this but it was discontinued at some point. It's now been ordered again. Here are some samples of how we write it. The one labeled IUO is how I write it. The other is how [name] wrote it. Either way is fine ....please let me know if you have any questions. Thanks, [Employee J]." An email dated 10/30/18 at 10:28 AM documented, "Good morning [Employee J] I am currently working on the report for [Resident #24] and have a couple questions ...what is [MD name]'s title? Is he/she active in [Resident #24]'s treatment? How did he/she learn about [Resident #24]'s injury? In other words, I'm trying to figure out how he ended up telling us about the ecchymosis ...Any info you can share would be helpful. [Employee H]." An email dated 10/30/18 at 11:05 AM documented, "Hi [Employee H], [MD name] is the Medical Director. So she's not on his direct caseload, but he oversees the care of all the pts (patients) and makes recommendations as needed. He's been here for years and is very familiar with her case. Hope that helps, [Employee J]." On 03/28/2019 at 12:45 PM, the Administrator provided "all the documentation" associated with the investigation which was seven pages. Included in the packet of papers: 1. Facsimile transmittal sheet dated 10/26/18 that was sent to the state agency on the day of incident 2. Facility Reported Incident Form dated 10/26/18 that was sent to state agency on the day of incident 3. A copy of the nurse's note dated 10/26/18 at 12:00 PM 4. A copy of the NP progress note dated 10/26/18	F 610		

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F 610	Continued From page 34 at 10:15 AM 5. A Facility Event Report dated 10/26/18 6. Handwritten notes by Employee H dated 10/26/18. 7. Typewritten report by Employee H dated 10/26/18 The Facility Event Report was a document with many boxes to select as relevant. The event date was 10/26/18. The event time was 9:50 AM. "Unexplained" was selected for "Type of Event." "Bedroom" was select for "Location." "Bruise" was selected for "Type of Injury." Under the section "Describe Event, it was documented, "Staff reported patient had discoloration to right 3rd and 5th fingers. Fifth right digit knuckle slightly swollen and purple in color. No break in skin." Under the section "Treatment/Interventions", it was documented, "NP in to assess patient. New order to x-ray right hand/3rd-5th fingers discoloration to right 3-5th fingers. Ice to right hand 15 min every 4 hours x 24 hours." Nurse was notified on 10/26/18 at 9:55 AM. MD/NP notified 10/26/18 at 10:00 AM. Supervisor was notified 10/26/18 at 11:00 AM. The form was signed by the RN (registered nurse) completing the form. The copy of the handwritten notes by Employee H (investigator) was a lined paper that documented: "10/26/18 [Resident #24's last name] IUO [injury of unknown origin] No known injury/accident-nothing documented [name] - Mdirector Pt has ecchymosis - has had long time Vitamin C for symptoms. quit taking new order."	F 610		

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F 610	Continued From page 35 On 03/28/2019 at 1:15 PM, a telephone interview with Employee H was conducted. Employee H verified that the notes listed above were her handwritten notes of the investigation. When asked about her investigation process, she stated that Resident #24 was not able to speak so she reviewed Resident #24's chart. When asked if she spoke with any of the staff or interviewed anyone in the course of her investigation, she stated, "No." The typewritten report by Employee H was dated 10/26/2018. Under the section "Description of Incident" it was documented, "Incident of Unknown Origin: Resident was found with bruising to her right hand at approximately 0950 hours in the morning of Friday, 10/26/2018. Interdisciplinary notes from 10-26-18 written by [name] RN stated there was discoloration to right 3rd and 5th fingers with 5th right digit knuckle noted to be slightly swollen and purple in color. There was no break in skin, no active bleeding, no wincing or facial grimacing when palpating the fingers. At approximately 1015 hours, FNP (family nurse practitioner) [name] assessed [Resident #24] and an x-ray of her right hand (3rd and 5th fingers) was ordered. An order for ice to the right hand every 15 minutes every 4 hours for 24 hours was also made. Continue to monitor." Under the section "Facility Action Taken" it was documented, "Facility and Clinical Director were notified on Friday 10/26/2018 and an IUO (injury of unknown origin) investigation was initiated. [State and federal agencies] notified. Reviewed interdisciplinary notes and spoke with nursing staff and [MD name], facility medical director. As the medical director, [name] oversees the patients at [facility] and is very familiar with	F 610		

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F 610	Continued From page 36 [Resident #24]. He stated the area appeared to be a result of ecchymosis. A condition [Resident #24] has had for quite some time and has taken vitamin C for in the past to aide (sic) with symptoms. A new order for vitamin C has been made. [Resident #24] has no documented symptoms of pain or distress from the injury. After further investigation, there are no new findings in this case." In summary, Resident #24 is completely dependent on staff for mobility and ADL care. An injury of unknown origin was identified on 10/26/18 but there is conflicting information in the clinical record documentation pertaining to the description and location of the injury (right hand versus 3rd and 5th fingers versus index finger). The practitioner ordered Vitamin C although Resident #24 had been receiving 150% of the daily recommended value of Vitamin C daily since 2010. The investigation did not include interviews with staff, potential witnesses, or practitioner to ensure Resident #24 was not a victim of abuse. The typewritten report by the investigator was dated 4 days prior to the email written by the investigator that stated, "I am currently working on the report for [Resident #24] ..." On 03/28/2019 at approximately 3:45 PM, the Administrator and the DON were notified of findings and they offered no further documentation of information. 2. For Resident #45, the facility staff failed to conduct an investigation for a fracture of unknown origin. Resident #45, was admitted to the facility on	F 610		

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F 610	Continued From page 37 9/22/09. Diagnoses included but were not limited to: profound intellectual disability, Down's Syndrome with severe congenital hear disease, pulmonic stenosis, polycythemia secondary to chronic hypoxemia, chronic hypothyroidism, osteoporosis, Hepatitis B carrier, and self injurious behavior. Resident #45's most recent MDS (Minimum Data Set) (an assessment tool) with an ARD (assessment reference date) of 12/5/18 was coded as a quarterly assessment. Resident #45 was coded as having severe cognitive impairment. The resident was also coded as requiring limited assistance of two staff members for transfers, and being totally dependent on staff for dressing, toileting and bathing. Resident #45 required supervision of one staff member for eating. During clinical record review on 3/27/19 and 3/28/19, of the nursing notes, physician progress notes, nursing assessments and social worker notes there was no indication of an investigation. Nursing notes read on 8/28/19 resident was "observed sitting up in w/c (wheel chair) @ (at) nursing station. Observed rubbing hard headphones against left shoulder area. Small purple bruise noted on left shoulder." Nursing notes dated 9/1/18 read, "noted to have 2 new parallel areas of bruising to left shoulder and left anterior chest. Fading bruising remains to top of left shoulder and anterior left chest skin intact." Nursing notes dated 9/5/18 read "bruise to l (left) shoulder spreading down to L (left) breast." Nursing notes dated 9/6/18 read, "bruising of left shoulder, chest, & lower side remains. Seems to be protective guarding of moving left arm." On 9/7/18 x-ray results revealed a "non-displaced	F 610		

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	495113	A. BUILDING _____ B. WING _____	C 03/28/2019

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F 610	Continued From page 38 acute fracture of distal clavicle." On 3/27/19 at 9am, the Administrator was requested to provide investigation information for Resident #45's injury. A blue folder was provided. The folder contained the following 10 documents. 1. Investigator's summary dated 9/12/18 2. FRI (Facility reported incident) report which was submitted to the office of licensure 3. A facility event report dated 8/28/18 4. Interdisciplinary notes dated 8/27/18-9/9/18 5. Physician interdisciplinary notes dated 8/8/18-9/10/14 6. Physician orders dated 9/5/18-9/10/18 7. X-ray reports dated 9/7/18 8. Fax confirmation of APS (Adult Protective Services) notification of injury 9. A Letter dated 9/13/18 addressed to Resident #45's guardian with a certified mail receipt and signed return receipt card which notified her an investigation was being performed 10. A letter dated 9/14/18 addressed to Resident #45's guardian which read, "based on the preponderance of evidence, the case was found to be unsubstantiated for neglect and the case is now closed." The facility Administrator was asked again on 3/27/19 at 4:44pm and the morning of 3/28/19 to provide any additional investigation information regarding Resident #45. On 03/28/19 at 10:59 AM the Administrator said "there is nothing else." On 3/28/19 at 1:19pm a telephone call was made to Employee H, the investigator, and she stated "I looked through the chart at the documentation related to the issue." When asked if she interviewed any nursing staff, CNA staff, other residents, or radiology personal; she stated, "no ma'am."	F 610		

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F 610	Continued From page 39 The resident was unable to be protected from further abuse, as the Administrator and the Director of Nursing stated no staff had been interviewed during the investigation of abuse and neglect for Resident #45. Review of the facility Policy and Procedure titled: "Patient Abuse, Neglect, & Injuries of Unknown Origin; Prevention & Investigation of" with a revision date of 3/4/19 states, the purpose of the policy is "To provide guidance to staff concerning the prevention of patient/resident abuse and/or neglect, and to establish uniform procedures for the reporting and investigation of allegations of patient/resident abuse, neglect, or injuries of an unknown origin." The policy reads: "All unexplained fractures are reportable as alleged abuse/neglect." "(facility name) has zero tolerance for acts of abuse or neglect. Therefore, whenever an allegation of abuse or neglect is made, (Facility name) shall take immediate steps to protect the safety & welfare of patients/residents who may be victims of the alleged abuse or neglect, conduct a thorough investigation and take any action necessary to prevent future occurrences of abuse or neglect." The facility had no formal investigation of the fracture of unknown source, which was an allegation of abuse. The facility didn't have statements from any staff members involved in the care of the individual when the injury was identified. The facility staff failed to provide any protection of Resident #45 during the investigation, and failed to take any measures to prevent reoccurrence. The facility Administrator and Director of Nursing	F 610		

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F 610	Continued From page 40 were made aware of these findings on 3/28/19 at 2:16pm. No additional information was provided.	F 610		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) Aregistered nurse with responsibility for the resident. (C) Anurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident'srepresentative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based upon facility documentation review and clinical record review, the facility staff failed to	F 657	1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.** The physician consulted the speech therapist regarding viscosity of liquid the resident is to be given. An order was received on 3/29/19 to continue with nectar thickened liquid. There is no need to change the care plan since it already reflects nectar thickened liquids. The right hand mitten was added to resident's care plan on 3/29/19. 2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice.** RN case managers will be instructed to review all residents on their case load to ensure any change in condition and new problems are reflected on the residents' care plans. 3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.** The night shift charge nurses will check all new orders from the previous day to ensure they are reflected on the residents' care plans. Any discrepancies will be added to the care plan and noted corrected on the 24 hour chart check by the night shift charge nurse. The CNE will review 24 hour chart check in the morning report to ensure the new orders and identified problems are transcribed to the residents care plan as needed. A weekly care plan audit will be conducted by the shift supervisors to ensure 100% compliance.	

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F 657	Continued From page 41 review and revise a careplan for one Resident (Resident #13) in a survey in survey sample of 21 Residents. For Resident #13, the facility staff failed to review and revise the careplan to include the correct viscosity of thickened liquids and the use of a restraint to the right hand. The findings included: Resident #13, was admitted to the facility on 6/4/13. Diagnoses included but were not limited to: dementia, GERD (gastro esophageal reflux disorder), glaucoma, incontinence of urine, self-injurious behavior, impaired mobility, TBI (traumatic brain injury) post MVA (motor vehicle accident), and atherosclerosis. Resident #13's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 1/4/19 wascoded as a quarterly assessment. Resident #13 was coded as daily decision making being severely impaired. The resident was also coded as being totally dependent, requiring the assistance of two staff persons, for bed mobility, transfers, dressing, toileting, personal hygiene and bathing. Review of physician orders indicated the resident is to receive honey thickened liquids. An order written 3/5/19, read "resume lunch- pureed diet via honey thickened liquids from today 3/5/19-3/11/19. Typed physician orders, signed by the provider on 3/6/19 read, "lunch-pureed diet honey thickened liquids starting 3/5/19 through 3/11/19." A Physician's order written 3/13/19 read, "resume diet as ordered in am (pureed) with	F 657	4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.** All residents' care plans will be reviewed at the weekly interdisciplinary team conferences and revised if needed. The results of audits will be submitted to the QAPI manager monthly for any further recommendations. 5. **Include dates when the corrective action will be completed. (The "outside" date by which all corrections must be made is the 45th calendar day after the survey ended.)** The "outside" date by which all corrections will be made is the May 4, 2019.	

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F 657	Continued From page 42 honey thickened liquids." Physician order written 3/19/19, read, "may have liquids (honey thickened) until 10am." Review of the careplan, with a team date of 1/9/19 read, "(resident name) receives Nectar liquids or soda per orders and during recreational parties." An undated, handwritten entry on the careplan reads, "(resident's name) diet is pureed with Nectar fluids when eating p.o (by mouth)." A Physician Order dated 3/23/19 was written for a "right hand mitten" valid for 7 days. Review of the careplan with a team date of 1/9/19 had a line through the typewritten text of "mitten to right hand." A handwritten entry, dated 2/26/19 was written on the careplan which read, "trial reduction of (resident's name) rt. (right) hand mitten x 7d (days), if self injury occurs, resume rt hand mitten 2/26-3/5/19." Another handwritten entry dated 3/8/19 read, "rt hand mitten d/c'd (discontinued)." Review of the facility document, "Careplan Clinical Procedure" with a review date of 7/15/18 read, "the comprehensive care plans are changed or revised by the RN to reflect changein conditions and new problems identified by the physician." The Administrator and DON were informed of the failure of staff to review and revise the careplan for Resident #13 thickened liquids and right hand mitten, on 3/28/19 at approximately 3pm. No further information was provided.	F 657		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	F 658	1. **Address corrective action will be accomplished for those residents found to**	

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F 658	Continued From page 43 §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, clinical record reviews, and facility documentation, the facility staff failed to ensure professional practice standards for medication administration for 4 residents (Resident #38, Resident #2, Resident 11 #, Resident #13) in a sample size of 21. 1. For Resident #38, the facility staff failed to administer medications via gastrostomy tube according to professional practice standards. 2. For Resident # 2, the facility staff failed to document the administration of medications as ordered by the physician 3. For Resident #11 the facility staff failed to follow physicians order and administered Tramadol twice in one day when it was ordered daily at 6:30 AM. 4. For Resident #13, the facility staff failed to obtain weights as ordered by the physician The findings include: 1. For Resident #38, the facility staff failed to administer medications via gastrostomy tube according to professional practice standards. Resident #38, a 52-year old male, was admitted	F 658	**have been effected by the deficient practice.** The physician was notified regarding the failure to administer Tramadol as ordered. The specific nurse involved was reeducated on the proper procedure for medication administration via gastrostomy tube on the same day the surveyor noted her deficient technique for administering medication via gastrostomy tube. Follow-up training will be conducted on the five rights of medication administration and medication administration via gastrostomy tube by the clinical educator. There were no noted effects found regarding failure to document medication administration for resident #2 and failure to obtain weights as ordered for resident #13. 2. **Address how the facility will identify other residents having potential to be affected by the same deficient practice.** All residents have the potential to be affected by the deficient practice of nurses failing to document the administration of medications as ordered by the physician and to obtain weights as ordered. 3. **Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur.** The specific nurse involved with the deficient medication administration and administering medications via gastrostomy tube practice will be retrained by the Clinical Educator to ensure she meets professional nursing standards when administering medication. She will be observed during medication pass to ensure she is proficient and competent in all aspects of administering medications per professional standards of practice. All nurses will be re-educated regarding documentation of medications and treatments given. A check of all residents with specific orders to be weighed will be conducted to ensure physician orders are being followed. All nurses will be in-serviced by the Clinical Educator regarding the facility's policy and procedure on documentation of medication administration and checking to ensure weights are obtained as	

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F 658	Continued From page 44 to the facility on 05/04/1984. Diagnoses include but not limited to profound intellectual disability, chronic aspiration syndrome, reflux esophagitis, quadriplegia, and seizure disorder. Resident #38's most recent Minimum Data Set (MDS) had an Assessment Reference Date (ARD) of 02/25/2019 and was coded as a quarterly assessment. Resident #24 was not coded for a Brief Interview of Mental Status (BIMS). Cognitive skills for daily decision-making were coded as severely impaired. Functional status for bed mobility, transfers, eating (tube feedings), dressing, and personal hygiene were all coded as total dependence on staff. On 03/27/2019 at 9:40 AM, LPN C was observed at medication cart preparing to administer medications to Resident #38. Medications LPNC prepared to administer included but not limited to lansoprazole 30 mg (delayed-release orally disintegrating tablet) and Senna 8.6 mg tablet. LPN C opened each unit dose package and placed the whole (not crushed) lansoprazole tablet in a medicine cup and place the whole (not crushed) Senna tablet in a separate medicine cup. She placed them on a tray with the other medications to be administered, covered the tray with a cloth, and carried the tray to Resident #38's bedside. LPN C introduced herself to Resident #38 and stated, "I'm going to give you your medicines now." At that time, this surveyor asked LPN C to return to the medication cart in hall. When asked about the Senna, LPN C looked at the Medication Administration Record (MAR) and stated, "Oh, this shouldn't be given now." The administration time listed on the MAR was 1800. LPN C removed the Senna tablet from the tray, placed it in a plastic bag, and returned it to the	F 658	ordered. 4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.** Random medication observation passes will be conducted on all shifts by the shift supervisors to ensure compliance with facility policy and procedure. Immediate education will be provided if deficiency is found. The night shift supervisor will audit new orders for weights monthly to ensure staff compliance with physician orders. The results of medication observation pass and weight audits will be reported to the QAPI manager and the Chief Nurse Executive for recommendations for improvement if any deficiencies are found. 5. **Include dates when the corrective action will be completed. (The "outside" date by which all corrections must be made is the 45th calendar day after the survey ended.)** The "outside" date by which all corrections will be made is May 4, 2019.	

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F 658	Continued From page 45 medication cart drawer. LPN C then picked up the tray of medications and started to re-enter Resident #38's room. At that time, this surveyor then asked LPN C how the lansoprazole is to be given. LPN C stated, "I should crush it first." LPN C returned to the medication cart, placed the lansoprazole tablet in a plastic bag, crushed the tablet, and placed the powder in a medicine cup. LPN C now had 5 medications on the tray and a cup of water. At the bedside, LPN C checked for gastric residual volume with a 60 ml syringe and then flushed with water in between each medication. LPN C would draw up a medication in the 60 ml syringe with a large air bolus between the medication and the syringe plunger. LPN C would then attach the syringe to the gastrostomy tube and plunge the medication as well as the large air bolus into Resident #38's stomach. LPN C repeated that process two more times. LPN C reconstituted the lansoprazole with water at the bedside, removed the plunger from the syringe, attached the syringe to the gastrostomy tube, and poured the reconstituted lansoprazole into the syringe and it immediately drained into the gastrostomy tube. She poured water into the syringe to flush the medication and then repeated that process for the last medication. When LPN C was asked about administering medications through a gastrostomy tube, she stated, "I should've put them all in by gravity." When asked if she was aware of the amount of air she injected into Resident #38's stomach, she stated she didn't know. When this surveyor told her it was approximately 150 ml of air, she stated, "That's too much air." On 03/27/2019 at approximately 12:05 PM, the DON was asked what references are utilized for professional practice standards and she stated,	F 658		

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F 658	Continued From page 46 "CMS (Centers for Medicare and Medicaid Services), CDC (Centers for Disease Control and Prevention), AMA (American Medical Association)." She also provided a list of resources for nurses: Lippincott - Nursing Practice; Meg Gulanick, Judith Meyer: Nursing Care; Donita D'Amico, Colleen Barbarito: Health and Physical Assessment in Nursing; Mosby 2018 Drug book. On 03/27/2019 at approximately 5:45 PM, the DON was asked about the expectation of nurses when administering medications through a gastrostomy tube, she stated, "It shouldn't have air in it." She also stated that when air is added, that can "develop more problems." In the Seventh Edition of Lippincott Nursing Procedures under the section entitled "Tube Feedings" and the sub-heading "For gastric feeding" it stated, "If you're using a bulb or catheter-tip syringe, remove the bulb or plunger and attach the syringe to the pinched-off feeding tube to prevent excess air from entering the patient's stomach, causing distention." " ...fill the syringe with formula and release the feeding tube to allow formula to flow through it. The height at which you hold the syringe will determine the flow rate. When the syringe is three-quarters empty, pour more formula into it. To prevent air from entering the tube and the patient's stomach, never allow the system to empty completely." The facility staff provided their facility policy entitled, "Gastrostomy Tube Feedings." Section II Part D documented, "Water for flushing the gastrostomy tube after feeding and/or medication administration. Thirty to sixty ml of water is used	F 658		

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F 658	Continued From page 47 for flushing via gravity, unless otherwise ordered by physician." On 03/28/2019 at approximately 5:45 PM, the Administrator and DON were notified of findings and they offered no further documentation or information. 2. For Resident # 2, the facility staff failed to document the administration of medications as ordered by the physician. Resident # 2, an 57 year old female, was admitted to the facility on 1/30/2017. Her diagnoses included but were not limited to: Profound Intellectual Disability, Dysphagia, Reactive Airway Disease, Seizure Disorder and Aspiration Syndrome. The most recent Minimum Data Set assessment was a Quarterly assessment with an assessment reference date (ARD) of 3/12/19. Resident # 2 was coded as having severe cognitive impairment. Resident # 2 was coded as requiring total assistance of one staff person for Activities of Daily Living except she required total assistance of two staff persons for bathing and transfers. Resident # 2 was coded as always incontinent of bowel and bladder. On 3/27/2019, review of the clinical record was conducted. Review of March 2019 Medication Administration Record (MAR) revealed missing documentation of administration of medications on : Albuterol 0.83% inhalers solution inhale one vial	F 658		

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F 658	Continued From page 48 via nebulizer every 12 hours 3/9/2019 at 10:00 PM Budesonide 0.5 milligrams per 2 milliliters suspension inhale one vial via nebulizer every 12 hours 3/8/2019 at 10 AM Gabapentin 250 milligrams per 5 milliliters take 900 milligrams (18 milliliters) via G-tube (gastrostomy tube) on 3/11/2019 at 8:00 AM, 3/19/2019 at 2:00 PM Amox/Clav 250-62.5 milligrams per 5 milliliters take 10 milliliters via G-tube every 12 hours for 7 days- 3/27/19 at 12 noon Review of the February 2019 Medication Administration Record (MAR) revealed missing documentation of administration of medications on the following dates: Albuterol 0.83% inhalers solution inhale one vial via nebulizer every 12 hours 2/15/19 at 10 AM Budesonide 0.5 milligrams per 2 milliliters suspension inhale one vial via nebulizer every 12 hours 2/15/19 at 10 AM Diazepam 5 milligrams (1/2 tab) take a half tab every 12 hours via G-tube 2/15/19 at 10 AM Florastor Kids Packets mix one packet in water, juice, or non-carbonated beverage and take via G-tube twice daily 2/15/19 at 10 AM Gabapentin 250 milligrams per 5 milliliters take 900 milligrams (18 milliliters) via G-tube (gastrostomy tube) 2/15/19 at 8 AM	F 658		

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F 658	Continued From page 49 Oxcarbazepine 300 milligrams per 5 milliliters take 300 milligrams (5 milliliters) 2/15/19 at 8 AM Pataday 0.2 % eye drops place one drop in each eye once daily for the eye 2/15/19 at 10 AM Topiramate 200 milligrams take one tablet via G-tube twice daily 2/15/19 at 8 AM, 2/23/19 at 8 PM, 2/24/19 at 8 PM Vimpat 10 milligrams per milliliters solution take 150 milligrams (15 milliliters) via G-tube twice daily 2/15/19 at 8 AM, 2/24/19 at 8 PM Senna 8.6 milligrams tablet twice a day via G tube 2/15/19 at 10 AM On 3/27/19 at approximately 12:05 PM, the Director of Nursing presented a written note with a list of resources for professional standard including Lippincott - Nursing Practice. On 3/27/2019 at 3:05 PM, an interview was conducted with the Assistant Director of Nursing who stated nurses should document medications at the time of administration. The Director of Nursing and Administrator cited Lippincott as its Nursing professional guidance used by the facility. "Fundamentals of Nursing, by Lippincott", stated "The physician is responsible for directing medical treatment. Nurses follow physicians' orders unless they believe the orders are in error or harm clients." Guidance is given from Lippincott Solutions, "Safe Medication Administration Practices,	F 658		

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F 658	Continued From page 50 General" 10/02/2015. "Document all medications administered in the patient's MAR or EMAR (Electronic Medication Administration Record). If a medication wasn't administered, document the reason why, any interventions taken, practitioner notification, and the patient's response to interventions." Additional Guidance from Lippincott's Nursing Center.com (www.nursingcenter.com) Rights of Medication Administration 1. Right patient " Check the name on the order and the patient. " Use 2 identifiers. " Ask patient to identify himself/herself. " When available, use technology (for example, bar-code system). 2. Right medication " Check the medication label. " Check the order. 3. Right dose " Check the order. " Confirm appropriateness of the dose using a current drug reference. " If necessary, calculate the dose and have another nurse calculate the dose as well. 4. Right route " Again, check the order and appropriateness of the route ordered. " Confirm that the patient can take or receive the medication by the ordered route. 5. Right time " Check the frequency of the ordered medication. " Double-check that you are giving the ordered dose at the correct time. " Confirm when the last dose was given. 6. Right documentation " Document administration AFTER giving the	F 658		

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F 658	Continued From page 51 ordered medication. " Chart the time, route, and any other specific information as necessary. For example, the site of an injection or any laboratory value or vital sign that needed to be checked before giving the drug. 7. Right reason " Confirm the rationale for the ordered medication. What is the patient's history? Why is he/she taking this medication? " Revisit the reasons for long-term medication use. 8. Right response " Make sure that the drug led to the desired effect. If an antihypertensive was given, has his/her blood pressure improved? Does the patient verbalize improvement in depression while on an antidepressant? " Be sure to document your monitoring of the patient and any other nursing interventions that are applicable. Reference: Nursing2012 Drug Handbook. (2012). Lippincott Williams & Wilkins: Philadelphia, Pennsylvania. www.nursingcenter.com Accessed online 3/29/2019. On 3/27/2019 during the end of day debriefing, the facility Administrator and Director of Nursing were informed of the findings of missing documentation of medications. The Administrator stated the Director of Nursing had identified the issue of missing documentation of medication administration in February 2019 and had done a plan of correction to address the problem. The Administrator was informed that the issue had not been resolved since there was evidence of continued missing documentation of medication administration since the problem was identified. The Director of Nursing stated she would	F 658		

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F 658	Continued From page 52 continue to educate the nursing staff on the importance of documentation of medication administration at the time of administration. No further information was provided. 3. For Resident #11 the facility staff failed to follow physicians order and administered Tramadol twice in one day when it was ordered daily at 6:30 AM. Resident # 11 a 48 year old man admitted to the facility on 4/2/03 with diagnoses of but not limited to Cerebral Palsy, Ulcerative Colitis, Seizure Disorder. On 3/28/19 during clinical record review it was noted on the Physicians Order Sheet that the Resident #11 several orders for pain medications as follows: 1. Acetaminophen Soln [Tylenol solution] 650 MG /20 ML [Milliliters] Take 20 ML via G-Tube Every 12 Hours (at 1000 and 2200) [10 AM and 10 PM] as directed. 2. Acetaminophen Soln - Every 6 hours as needed for pain or temp 100.5 or above. Max of 4000 MG/day 3. Fentanyl [Narcotic pain medicine] 25 MCG/HR [Micrograms per Hour] apply one patch every 72 hours. Remove old patch alternate sites.*External Use* 4. Tramadol HCL [Narcotic pain medicine] 50 MG -Take 1 tablet Via G-Tube at 6:30 AM	F 658		

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F 658	Continued From page 53 Upon further review it was discovered that the Resident was given two doses of Tramadol 50 MG on 3/27/19. The Narcotic Control sheet documented Resident # 11 being given Tramadol 50 MG as ordered at 6:30 AM by LPN E the night shift nurse (11 PM-7:30 AM shift). A second entry in the Narcotic Control sheet on 3/27/19 shows LPN C (Day Shift 7 AM-3:30 PM) also gave the Resident a 50 MG dose of Tramadol however no time of administration was entered on the narcotic sheet. According to the Physician Interdisciplinary Notes the Nurse Practitioner 3/27/19 1450 [2:50 PM] - Noted that Resident received extra dose of Tramadol this AM. Pt sleepy but awakens to stimulation / voice T-97.8 [temperature] P-104 [Pulse]-R-18 [Respirations] O2 Sat. 94% on room air [Oxygen Saturation] B/P 107/72 [Blood Pressure] Monitor vital signs q shift [every shift] with O2 Sat monitoring. According to the DON the Professional Guidance used for nursing is Lippincott. According to Lippincott the eight rights of medication administration are: 1. Right patient- Check the name on the order and the patient. Use 2 identifiers. Ask patient to identify himself/herself. When available, use technology (for example, bar-code system).	F 658		

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F 658	Continued From page 54 2. Right medication-Check the medication label. Check the order. 3. Right dose-Check the order. Confirm appropriateness of the dose using a current drug reference. If necessary, calculate the dose and have another nurse calculate the dose as well. 4. Right route- Again, check the order and appropriateness of the route ordered. Confirm that the patient can take or receive the medication by the ordered route. 5. Right time-Check the frequency of the ordered medication. Double-check that you are giving the ordered dose at the correct time. Confirm when the last dose was given. 6. Right documentation-Document administration AFTER giving the ordered medication. Chart the time, route, and any other specific information as necessary. For example, the site of an injection or any laboratory value or vital sign that needed to be checked before giving the drug. 7. Right reason- Confirm the rationale for the ordered medication. What is the patient's history? Why is he/she taking this medication? Revisit the reasons for long-term medication use. 8. Right response-Make sure that the drug led to the desired effect. If an antihypertensive was given, has his/her blood pressure improved? Does the patient verbalize improvement in depression while on an antidepressant? Be sure to document your monitoring of the patient and any other nursing interventions that are applicable.	F 658		

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F 658	Continued From page 55 Reference: Nursing2012 Drug Handbook. (2012). Lippincott Williams & Wilkins: Philadelphia, Pennsylvania. On 3/28/19 at 3:30 PM an interview was conducted with the DON who stated she was aware that the dayshift nurse had given the extra dose of Tramadol and that they did contact the physician and written a medication variance. DON also stated she would give LPN C additional in-service training on medication administration. On 3/28/19 the Administrator was made aware during the end of day conference and no additional information was provided 4. For Resident #13, the facility staff failed to obtain weights as ordered by the physician. Resident #13, was admitted to the facility on 6/4/13. The resident's diagnosis included but were not limited to: dementia, GERD (gastro esophageal reflux disorder), glaucoma, incontinence of urine, self-injurious behavior, impaired mobility, TBI (traumatic brain injury) post MVA (motor vehicle accident), and atherosclerosis. Resident #13's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 1/4/19 was coded as a quarterly assessment. Resident #13 was coded as daily decision making being severely impaired. The resident was also coded as being totally dependent, requiring the assistance of two staff persons, for bed mobility, transfers,	F 658		

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F 658	Continued From page 56 dressing, toileting, personal hygiene and bathing. Review of physician orders signed by the nurse practitioner on 3/6/19 revealed an order that read "obtain weight tonight (3-5-19) then weight 6 days weekly x 4 weeks. START 3-5-19 STOP 4-1-19." These orders were also signed on 3/6/19 by an RN that indicated she had read and checked the orders on 3/6/19. On 3/28/19 during record review, which included review of nursing notes and weight flow sheets; the weights had not been obtained 6 days weekly, as ordered. Weights were documented as having only been obtained on 3/5/19, 3/6/19, 3/14/19, 3/20/19, and 3/27/19. The facility staff failed to obtain weights on 14 occasions as ordered. During an interview with the DON (Director of Nursing) on 3/28/19 she reviewed Resident #13's clinical record and acknowledged that weights had not been obtained as ordered. The Administrator and DON were informed of the failure of staff to obtain weights as ordered on 3/28/19 at approximately 3pm. No further information was provided.	F 658		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or	F 757	1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.** Resident #11's attending physician was notified. The attending physician assessed and monitored, and a medication variance was completed. The staff member involved in the deficient practice received a review of Rights of Medication Administration and Clinical Procedure 100 "Reporting of Medication Variances", along with a Post Test on 4/9/19.	

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F 757	Continued From page 57 §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility documentation the facility staff failed to ensure freedom from unnecessary drugs for 1 Resident (Resident #11) in a survey sample of 21 Residents. For Resident # 11 the facility staff administered Tramadol (narcotic pain medicine) 50 MG (Milligrams) twice on 3/27/19 when the order was for Tramadol 50 MG once daily at 6:30 AM. The findings included; Resident # 11 a 48 year old man, was admitted to the facility on 4/2/03 with diagnoses of but not limited to Cerebral Palsy, Ulcerative Colitis, Seizure Disorder. On 3/27/19 during clinical record review it was noted on the Physicians Order Sheet that the Resident #11 had several orders for pain medication as follows:	F 757	2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice.** All resident have the potential to be a risk. 3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.** The Nursing Supervisor and the Clinical Educator will conduct "Medication Pass Technique" audits with 100% of the nurses. The Clinical Educator will orient new hires on the rights of medication administration with Clinical Procedure 100 "Reporting of Medication Variances". Each Medication Administration record (MAR) book will have the rights of medication administration listed in front. 4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.** Unnecessary Drug use will be monitored through medication variances being reported to the Chief Nurse Executive (CNE) daily. In the monthly QAPI meeting the unnecessary drug use reported through medication variance will be reviewed. 5. **Include dates when the corrective action will be completed. (The "outside" date by which all corrections must be made is the 45th calendar day after the survey ended.)** The "outside" date by which all corrections will be made is May 4, 2019.	

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F 757	Continued From page 58 1. Acetaminophen Soln [Tylenol solution] 650 MG /20 ML [Milliliters] Take 20 ML via G-Tube Every 12 Hours (at 1000 and 2200) [10 AM and 10 PM] as directed. 2. Acetaminophen Soln - Every 6 hours as needed for pain or temp 100.5 or above. Max of 4000 MG/day 3. Fentanyl 25 MCG/HR [Micrograms per Hour] apply one patch every 72 hours. Remove old patch alternate sites.*External Use* 4. Tramadol HCL 50 MG -Take 1 tablet Via G-Tube at 6:30 AM Upon further review it was discovered that the Resident was given two doses of Tramadol on 3/27/19. On the Narcotic Control sheet (Nurses sign off sheet) Resident # 11 was given Tramadol 50 MG as ordered at 6:30 AM by LPN D the night shift nurse (11 PM-7:30 AM shift on 3/27/19 According to the Narcotic Control sheet on 3/27/19 the day shift nurse LPN C (Day Shift 7 AM-3:30 PM) also gave the Resident another 50 MG dose of Tramadol however no time was entered on the narcotic sheet. According to the Physician Interdisciplinary Notes the Nurse Practitioner wrote on 3/27/19 at 2:50 PM, Noted that Resident received extra dose of Tramadol this AM. Pt sleepy but awakens to stimulation / voice T-97.8 [temperature] P-104 [Pulse]-R-18 [Respirations] O2 Sat. 94% on room air [Oxygen Saturation] B/P 107/72 [Blood Pressure] Monitor	F 757		

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F 757	Continued From page 59 vital signs q shift [every shift] with O2 Sat monitoring. On 3/28/19 at 3:30 PM, an interview was conducted with the DON who stated she was aware that the dayshift nurse had given the extra dose of Tramadol and that they did contact the physician and written a medication variance. DON also stated she would give LPN C additional in-service training on medication administration. On 3/28/19 the Administrator was made aware during the end of day conference and no additional information was provided.	F 757		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;	F 758	1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.** The attending physician involved in the deficient practice received a review of CMS regulation 483.45 (e) on Unnecessary drugs and PRN orders for Psychotropic drugs. 2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice.** All residents have the potential to be at risk. A 100% audit of all residents on PRN psychotropic drugs will be audited by a Pharmacist or Pharmacy designee for appropriateness for the PRN order to be extended beyond 14 days and documentation of rationale in the resident's medical record with indication of duration for the PRN order. 3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.** The Medical Director will in-service the attending physicians and nurse practitioner on CMS	

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F 758	Continued From page 60 §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility documentation the facility staff failed to ensure 2 Residents (Residents #35, and #46) were free from unnecessary psychotropic drugs in a survey sample of 21 Residents. 1. For Resident # 35, the facility staff used Ativan PRN (as needed) for more than 14 days without a diagnosis to support its continued use. 2. For Resident # 46 the facility staff only	F 758	regulation 483.45 (e) on Unnecessary Drugs and PRN orders for Psychotropic drugs. 4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.** Unnecessary Psychotropic Meds/PRN use will be monitored through a monthly audit conducted by a Pharmacist or Pharmacy designee. The results of the audit will be turned into the QAPI Manger monthly for any further recommendations. 5. **Include dates when the corrective action will be completed. (The "outside" date by which all corrections must be made is the 45th calendar day after the survey ended.)** The "outside" date by which all corrections will be made is May 4, 2019.	

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F 758	Continued From page 61 attempted 1 gradual dose reduction since start of Thioridazine 150 MG on 11/16/17 and no GDR for the other 3 psychotropic medications. The findings include: 1. For Resident # 35, the facility staff used Ativan PRN (as needed) for more than 14 days without a diagnosis to support its continued use. Resident #35 a 62 year old woman admitted to the facility on 12/23/1993 with diagnoses of but not limited to Schizophrenia, Involuntary Commitment, G-Tube feeding, Impaired mobility, Bilateral hand contractures, Seizure Disorder, Dialysis Dependent, and depression. On 3/25/19 at 3:00 PM a clinical record review was conducted and it was found that Resident # 35 was on several Psychotropic medications including: Lorazepam [Trade name- Ativan- an Anti-Anxiety] 2 MG every 8 hours PRN for agitation and yelling On 3/28/18 the DON was asked what the Ativan order read as indication for use. DON read from the Physicians order Lorazepam 2 mg. take 1 tablet via G-Tube every 8 hours as needed for Agitation/Yelling. When asked if agitation or yelling are diagnosis or symptoms she stated "Symptoms." When asked about having the Ativan as a PRN order for more than 14 days the DON stated she was unaware that they could only get the medication PRN for 14 days.	F 758		

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F 758	Continued From page 62 The Administrator was made aware of this issue during the end of day meeting on 3/28/19, no further information was provided. 2. For Resident # 46 the facility staff to only attempted 1 gradual dose reduction since Thioridazine (Anti-Psychotic) began on 11/16/17 and no GDR for Venlafaxine, Lorazepam, and Mirtazapine. Resident #46 a 75 year old woman admitted to the facility on 8/31/14 with diagnoses of but not limited to Dysphagia, Aspiration syndrome, Hypothyroidism, Hypertension, Impaired mobility, Obstructive Sleep Apnea, Bilateral hearing impairment, major depression, with anxiety, Bipolar type 1, Pacemaker, and Seizure disorder. On 3/25/19 at 3:00 PM a clinical record review was conducted and it was found that Resident #46 was on several Psychotropic medications including: 1. Thioridazine [Trade name -Thorazine an Anti-Psychotic] 50 MG take 3 tablets [to equal 150 mg] via g-tube every 8 hours. 2. Venlafaxine [Trade name Effexor - an Anti-Depressant] 75 MG 1 tab. via g-tube in morning and evening 3. Lorazepam [Trade name- Ativan- an Anti-Anxiety] 2 MG take 1 tab. three times daily at 0700 1300 and 2000 [7am, 1PM and 8PM] 4. Lorazepam [Trade name Ativan -an Anti-Anxiety] 1 MG take 1 tab. three times daily at 0700 1300, and 2000 [7AM, 1PM, and 8PM] 5. Mirtazapine [Trade name Remeron an Anti-Depressant] 7.5 MG 1 tab. via G-Tube at Bedtime as needed for Insomnia.	F 758		

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F 758	Continued From page 63 On 3/28/19 this surveyor requested GDR (Gradual Dose Reduction) for the psychotropic that Resident #46 was receiving. Administrator submitted a document titled Gradual Dose Reduction Guidance to Provider. The document stated: Psychotropic mediation initiated (enter date): 11/16/17 GDR Attempt: 1st Attempt List psychotropic medication in review: Thioridazine 150 MG every 8 hours. Guidance: Per CMS regulations a gradual dose reduction is recommended in the medication listed above. If a dose reduction is clinically appropriate consider reducing the 10 mg bedtime dose. Per American Psychiatric Association (APA) guidelines, a gradual reduction by 10% per month over a 6 to 24 months is preferred in order to avoid withdrawal and minimize the risk of relapse. [The document has the pharmacist Signature and date signed 11/9/18] Prescriber Response required (check box) [Box checked] Read but do not wish to implement Comments: [Doctor's name redacted] Consultation (recert.) Present medication will be continued for a while. Thanks for your suggestion. Physician Signature: [Redacted] Date: 11/13/18	F 758		

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F 758	Continued From page 64 On 3/28/19 the Administrator was asked if there were any further GDR's for any of the other meds or another attempt for the Olanzapine. She stated "No we have looked in both charts this is the only one we have." The Administrator was made aware of this issue during the end of day meeting on 3/28/19, no further information was provided.	F 758		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility documentation, the facility staff failed to ensure the medication error rate was less than 5%. There were 2 medication errors (wrong time/wrong route potentials) and 25 opportunities resulting in an 8% error rate. The findings included: Resident #38, a 52-year old male, was admitted to the facility on 05/04/1984. Diagnoses include but not limited to profound intellectual disability, chronic aspiration syndrome, reflux esophagitis, quadriplegia, and seizure disorder. Resident #38's most recent Minimum Data Set (MDS) had an Assessment Reference Date (ARD) of 02/25/2019 and was coded as a	F 759	1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.** The nurse involved in the deficient practice received a review of Rights of Medication Administration and Clinical Procedure 99 "Administration of Medication", along with a Post Test on 4/9/19. After the review, the Nursing Supervisor and the Clinical Educator will monitor the nurse involved in medication pass technique monthly for 6 months. 2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice.** All resident have the potential to be a risk. 3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.** The Nursing Supervisor and the Clinical Educator will conduct "Medication Pass Technique" audits with 100% of the nurses. The Clinical Educator will orient new hires on the rights of medication administration with Clinical Procedure 99 "Administration of Medication". Each Medication Administration Record (MAR) book will have the rights of medication listed in the front to ensure deficient practice will be less than 2% medication variance rate per quarter.	

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F 759	Continued From page 65 quarterly assessment. Resident #24 was not coded for a Brief Interview of Mental Status (BIMS). Cognitive skills for daily decision-making were coded as severely impaired. Functional status for bed mobility, transfers, eating (tube feedings), dressing, and personal hygiene were all coded as total dependence on staff. On 03/27/2019 at 9:40 AM, LPN C was observed at medication cart preparing to administer medications to Resident #38. Medications LPN C prepared to administer included but not limited to lansoprazole 30 mg (delayed-release orally disintegrating tablet) and Senna 8.6 mg tablet. LPN C opened each unit dose package and placed the whole (not crushed) lansoprazole tablet in a medicine cup and place the whole (not crushed) Senna tablet in a separate medicine cup. She placed them on a tray with the other medications to be administered, covered the tray with a cloth, and carried the tray to Resident #38's bedside. LPN C introduced herself to Resident #38 and stated, "I'm going to give you your medicines now." At that time, this surveyor asked LPN C to return to the medication cart in hall. When asked about the Senna, LPN C looked at the Medication Administration Record (MAR) and stated, "Oh, this shouldn't be given now." The administration time listed on the MAR was 1800. LPN C removed the Senna tablet from the tray, placed it in a plastic bag, and returned it to the medication cart drawer. LPN C then picked up the tray of medications and started to re-enter Resident #38's room. At that time, this surveyor then asked LPN C how the lansoprazole is to be given. LPN C stated, "I should crush it first." LPN C returned to the medication cart, placed the lansoprazole tablet in a plastic bag, crushed the tablet, and placed the powder in a medicine cup.	F 759	4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.** Medication variances will be reported to the Chief Nurse Executive (CNE) daily. The medication variance rate will be reported monthly in the QAPI meeting. 5. **Include dates when the corrective action will be completed. (The "outside" date by which all corrections must be made is the 45th calendar day after the survey ended.)** The "outside" date by which all corrections will be made is May 4, 2019.	

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F 759	Continued From page 66 LPN C now had 5 medications on the tray and a cup of water. At the bedside, LPN C checked for gastric residual volume with a 60 ml syringe and then flushed with water in between each medication. LPN C reconstituted the lansoprazole with water at the bedside, removed the plunger from the syringe, attached the syringe to the gastrostomy tube, and poured the reconstituted lansoprazole into the syringe and it immediately drained into the gastrostomy tube. She poured water into the syringe to flush the medication. The current physician's orders signed and dated 03/26/2019 documented, "Senna 8.6 mg tablet. Take one tablet via G-tube at 1800. Hold for diarrhea." "Lansoprazole ODT (orally-disintegrating tablet) 30 mg Take 1 capsule once daily via G-tube." On 03/27/2019 at approximately 11:55 AM, Employee E, a pharmacist, was asked how lansoprazole ODT should be administered, she read the physician's order for Resident #38 and stated to "give one via G-tube." When asked if it could be crushed, she stated, "we don't specify" whether or not to crush the med but "all meds we send up" can be crushed if necessary. On 03/27/2019 at approximately 12:05 PM, the DON was asked what references are utilized for professional practice standards and she stated, "CMS (Centers for Medicare and Medicaid Services), CDC (Centers for Disease Control and Prevention), AMA (American Medical Association)." She also provided a list of resources for nurses: Lippincott - Nursing Practice; Meg Gulanick, Judith Meyer: Nursing Care; Donita D'Amico, Colleen Barbarito: Health and Physical Assessment in Nursing; Mosby	F 759		

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F 759	Continued From page 67 2018 Drug book. The manufacturer's prescribing information publication for lansoprazole (Prevacid) delayed-release orally disintegrating tablets (ODT) under Section 2.3 entitled, "Important Administration Information" and sub-header "Prevacid SoluTab ODT" documented, "Prevacid SoluTab should not be broken or cut. Prevacid SoluTab should not be chewed. Place the tablet on the tongue and allow it to disintegrate, with or without water, until the particles can be swallowed. The tablet typically disintegrates in less than 1 minute. Alternatively, for children or other patients who have difficulty swallowing tablets, Prevacid SoluTab can be delivered in two different ways" oral syringe or nasogastric tube. Under the sub-header "Prevacid SoluTab ODT - Nasogastric tube (? 8 French) Administration" , it documented, " ...place a 30 mg tablet in a syringe and draw up 10 ml of water. Shake gently to allow for a quick dispersal. After the tablet has dispersed, administer the contents within 15 minutes. Refill the syringe with approximately 5 ml of water, shake gently, and flush the nasogastric tube." The manufacturer's prescribing information does not specifically address gastrostomy tube but a nasogastric tube and a gastrostomy tube both terminate in the stomach. On 03/27/2019 at approximately 5:45 PM, the DON was asked about the expectation of nurses when administering medications and she stated that the nurse should double-check the MAR after preparing the medications and before administering them to the patient. In the Seventh Edition of Lippincott Nursing Procedures under the section entitled "Safe	F 759		

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F 759	Continued From page 68 Medication Administration Practices, General" it documented, "To promote a culture of safety and to prevent medication errors, nurses must avoid distractions and interruptions when preparing and administering medications, and adhere to the "five rights" of medication administration: identify the right patient by using at least two patient-specific identifiers; select the right medication; administer the right dose; administer the medication at the right time; and administer the medication by the right route." On 03/28/2019 at approximately 5:45 PM, the Administrator and DON were notified of findings and they offered no further documentation or information.	F 759		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of	F 761	1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.** No residents were noted to be affected by this deficiency. The vials of Novolog and Aplisol were returned to the pharmacy. 2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice.** All residents that have prescribed medications dispensed in vials have the potential to be affected by this deficiency. 3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.** All multi dose vials of medications will be checked daily to ensure they are dated and stored according to the manufacturer's specifications by the medication nurses. The vials of Aplisol and Novolog were returned to the pharmacy due to being opened and not dated and not stored according to the manufacturer's instructions. The Pharmacy Director will revise her policy on medication storage to add the manufacturer's	

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F 761	Continued From page 69 the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility documentation, the facility staff failed to label and store medications according to manufacturer's specifications in one of two facility medication rooms. Specifically, the facility staff failed to: -date a multi-dose vial of Aplisol (tuberculin PPD) after accessing the vial -date a multi-dose vial of Novolog in accordance with manufacturer's specifications -store a multi-dose vial of Novolin N according to manufacturer's specifications The findings include: On 03/26/2019 at approximately 3:15 PM, the medication room on the second floor was surveyed. LPN A and this surveyor observed multi-dose vials in the refrigerator. An open box of Aplisol had a pharmacy label that documented, "Stock" on it. LPN A stated the facility has an in-house pharmacy that placed the label on the box. Inside the box was a multi-dose vial of Aplisol and it did not have a plastic top on it. When asked if that vial had been opened and accessed, LPN A stated, "Yes." There was not a date on the bottle or the box to indicate when it was opened. LPN A held it in her hand and stated it needed to be returned to the pharmacy because it wasn't dated therefore unknown when it was opened. An open box of Novolog hada	F 761	recommendations for storage of multi dose vials of insulins and dating of multi dose vials of medications on the vial itself rather than on the manufacturer's box the medication is stored in. The Clinical Educator will in-service all nurses on the new policy and procedure changes for dating and storing multi dose vials of medication. 4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.** The medication refrigerator will be checked by the unit manager or shift supervisor to ensure multi dose vials of medications are properly stored and dated according to the manufacturer's recommendations to ensure we have 100% compliance. The pharmacy will conduct monthly inspections of all medication refrigerators and the results of the inspections will be submitted to the QAPI Manager for tracking and recommendations as needed. 5. **Include dates when the corrective action will be completed. (The "outside" date by which all corrections must be made is the 45th calendar day after the survey ended.)** The "outside" date by which all corrections will be made is May 4, 2019.	

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F 761	Continued From page 70 small yellow sticker on it with the typewritten words, "Do not use beyond_____(date)." There was a date of 04/05/19 handwritten in the space provided. When asked about the process for dating medications, LPN A stated the "Do not use beyond" date is 30 days from the date it was opened. The vial of Novolog inside the box did not have a plastic cover and it was not dated. An open box of Novolin N had a small yellow sticker on it with the typewritten words, "Do not use beyond_____(date)." There was a date of 04/19/19 handwritten in the space provided. The multi-dose vial of Novolin N inside the box did not have a plastic cover and it was not dated. On 03/27/2019 at approximately 5:45 PM, a copy of the medication inserts for Aplisol, Novolog, and Novolin N were requested as well as the policy for medication storage and labeling. On 03/28/2019, the DON provided the medication inserts that were requested. Under the header "Storage" on the Aplisol medication insert, it documented, "Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency." On the Novolog insert under the header "How should I store Novolog?" it documented, "Opened Novolog vials should be thrown away after 28 days, even if they still have insulin left in them." On the Novolin N insert under the header "How should I store Novolin N?" it documented for Novolin N vials in use, "Keep at room temperature below 77 degrees Fahrenheit for up to 6 weeks (42 days). Keep vials away from direct heat or light. Do not refrigerate an opened vial." On 03/28/2019, the facility staff provided a policy entitled, "Medication Storage." The policy does	F 761		

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F 761	Continued From page 71 not address the practice of dating multi-dose vials once opened. In Section R entitled, "Drugs requiring refrigeration or temperature control must be maintained at proper temperature" documented parameters for "cold", "room temperature", "warm", and "excessive heat." A copy of the "Temperature Control Sheet" for the medication room on the second floor was requested. On 03/28/2019 at 11:40 AM, an interview with the DON was conducted. When asked who determines what medications are refrigerated, the DON stated it is a "combination of nursing and pharmacy" and she went on to say that "pharmacy shares with nursing how to store medications." On 03/28/2019 at 12:20 PM, an interview with Employee E, a pharmacist, was conducted. When asked about the process for storing multi-dose vials, Employee E stated "We want to stick with manufacturer's recommendations." When shown the medication insert for Novolin N storage specifications, Employee E stated, "I didn't know that" Novolin N should not be refrigerated after opening. When asked about the process for dating multi-dose vials, Employee E stated that the yellow round stickers on the boxes are placed on the box by pharmacy staff and the "nurses date it when they open it." A copy of pharmacy policies on medication storage and labeling was requested. On 03/28/2019 at approximately 12:25 PM, the DON presented a copy of a document entitled, "March 2019 Temperature Control Sheet, 2nd Floor." Employee E and the DON verified the temperature column labeled, "Room" was the	F 761		

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F 761	Continued From page 72 room temperature of the medication room and the temperature column labeled "Refrigerator" was the temperature of the medication refrigerator in the medication room. For 03/26/2019 (the day the Novolin N was observed in the refrigerator), the room temperature was recorded as 72.9 degrees Fahrenheit and the refrigerator temperature was recorded as 36 degrees Fahrenheit. On 03/28/2019 at 1:45 PM, Employee E provided a policy entitled, "Pharmacy Services." Section K entitled "Medication Dispensing" does not address labeling/dating procedures/parameters for multi-dose vials. Section O entitled "Drug Storage and Security" does not address storage procedures/parameters for multi-dose vials. On 03/28/2019 at approximately 5:45 PM, the Administrator and DON were notified of findings and they offered no further documentation or information.	F 761		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility	F 842	1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.** There were no noted effects suffered by resident #3 from failure to accurately document the intake of G-tube feeding and flushes. 2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice.** All residents receiving G-tube feedings and flushes are at risk to be affected by this deficient practice. 3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.**	

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F 842	Continued From page 73 must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law.	F 842	The Unit Manager and the Nursing Supervisor will conduct 100% education of all Registered Nurses and Licensed Practical Nurses on accurately documenting the intake of G-tube feedings and flushes. Each shift the Licensed Practical Nurse will check for any documentation that is not completed, ensuring accurate documentation of G-tube feedings and flushes. 4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.** Each book is assigned to a Registered Nurse to audit during the week for complete documentation. The Chief Nurse Executive will receive the report weekly. If any deficiencies are found in the documentation, corrective action will take place by the Unit Manager and the Nursing Supervisors. The results of the audit will be turned into the QAPI Manger monthly for any further recommendations. 5. **Include dates when the corrective action will be completed. (The "outside" date by which all corrections must be made is the 45th calendar day after the survey ended.)** The "outside" date by which all corrections will be made is May 4, 2019.	

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F 842	Continued From page 74 §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility documentation the facility staff failed to ensure an accurate clinical record for 1 Resident (Resident # 3) in a survey sample of 21 Residents. For Resident #3 the facility staff failed to accurately document the intake of G-Tube feeding and flushes. The findings include: Resident #3 a 25 year old woman admitted to the facility on 11/15/18 with diagnoses of but not limited to intellectual Disability, G-Tube, and Aspiration syndrome, Cerebral Palsy with contractures of extremities, hyper salivation, incontinence, and weight loss from neglect. On 3/27/19 during clinical record review it was noted that Resident #3 had G-Tube feeding ordered and that there were a lot of blank spaces in the documentation from 1/1/19 to 3/27/19. The Tube feeding orders were as follows:	F 842		

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F 842	Continued From page 75 Jevity 1.5 400 ML every 6 hours at 200 ML per hour over 2 hours. Flush with 300 ML of water every 6 hours. On January 2019 G-Tube Feeding Record there were empty spaces (no nurse's initials) for the following dates Check Tube Placement - Dayshift - Jan 11, 14, 16, 17, 30 also Nightshift for Jan 30th Document Residual - Dayshift - Jan 7, 11, 16, 17, and 27th Tube Feeding - 12:00 - Jan. 11, 13, 16, 17, and 30th In addition, flushes were being documented as 300 ML per shift instead of 300 ML every 6 hours On February G-Tube Feeding Record there were empty spaces (no nurse's initials) for the following dates: Check Tube Placement - Dayshift - Feb 5th and Feb 22nd and Evening shift on 19th Document Residual - Dayshift - Feb 5th and Nightshift on the 10th Tube Feeding 12:00 - Feb 5th 1800 [6PM] -Feb 19th 2400 [midnight] Feb 22, 26th and 27th In addition, flushes were being documented as 300 ML per shift instead of 300 ML every 6 hours and missing on the 5th and 22nd on Day shift and	F 842		

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F 842	Continued From page 76 the 22nd on Evening shift. For March 2019 G-Tube Feeding Record there were empty spaces (no nurse's initials) for the following dates. Document Residual - Dayshift - March 4th, 9th, 14th and 15th and Night shift on the 6th Tube Feeding - 12:00 -March 22nd 1800 [6 PM] - March 4th In addition, flushes were being documented as 300 ML per shift instead of 300 ML every 6 hours and not documented on March 22nd day shift. On 3/28/18 at 4:00 PM an interview was conducted with the DON who stated she was aware there was a problem and did in-servicing with the staff responsible for G-Tube documentation. The Administrator was made aware during the end of day meeting on 3/28/19 and no further information was provided.	F 842		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880	1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.** No residents suffered ill effects from the clothing protectors due to the CNA allowing the clothing protectors to touch her clothing first as she passed out the clothing protectors to the residents. 2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice.** All residents have the potential to be affected by	

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F 880	Continued From page 77 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct	F 880	transport and distribution of clothing protectors in the manner noted above. 3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.** The Resident dining policy will be revised to include instructions for the correct procedure to transport and distribute clothing protectors to prevent the spread of infection. The Infection Control Nurse will provide an in-service training to all nursing staff on the revised policy to ensure all clinical staff are aware of the correct procedure for transport and distribution of clothing protectors to residents in the dining area. 4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.** The CNA Team Leaders will monitor the dining area during meal times to ensure staff maintains compliance with regulatory requirements for transport of linens to prevent infection. Any noncompliance will be corrected immediately and reported to the shift supervisor for further education as needed. The Infection Control Nurse will conduct a weekly audit of each meal time until sustained compliance is achieved. The results will be submitted to the monthly QAPI Committee for any further recommendations if needed. 5. **Include dates when the corrective action will be completed. (The "outside" date by which all corrections must be made is the 45th calendar day after the survey ended.)** The "outside" date by which all corrections will be made is May 4, 2019.	

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F 880	Continued From page 78 contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility staff failed to transport linen in a manner to prevent the spread of infection in one of two dining areas. In one of two dining areas during meal service the facility staff failed to distribute clothing protectors in a manner to prevent the spread of infection. The findings included: On 3/27/19 from 11:11am until 11:21am, during observation of meal service on the third floor, CNA F (certified nursing assistant) , CNA G, and LPN D (licensed practical nurse) were holding clothing protectors against their body, which was touching their clothing, while they were distributing the clothing protectors to residents. On 03/28/19 at 11:15 AM, during an interview with	F 880		

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F 880	Continued From page 79 RN A, when asked how should staff transport linens, she replied "staff would wash their hands, obtain linen for what they need, and carry it holding it not against their clothing or anything like that." On 3/28/19 at 2:26pm during a meeting with the Administrator and DON when asked what their expectations regarding linen transport, the DON replied, "hold it in their hands, not touching their body." The Administrator and DON were made aware of staff's failure to transport linen in a manner to prevent the spread of infection during end of day meeting on 3/28/19 at 2:26pm. No further information was provided.	F 880		
F 908 SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to ensure equipment was in safe operating condition for one Resident (Resident #45) in a survey sample of 21 Residents. For Resident #45, the facility staff failed to maintain a bed in safe operating condition to prevent resident exposure to open electrical wiring. The findings included:	F 908	1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.** The resident's bed was disconnected from the wall receptacle and a STAT work order was completed on the day found. 2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice.** All residents have the potential to be affected by exposed electrical wiring. 3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.** CNA Team Leaders on all shifts will be instructed to check for exposed wiring on beds to ensure residents are not exposed to unsafe conditions posed by open electrical wiring. This will be added to the CNA Team Leaders rounds checklist for every shift. The CNA will immediately disconnect any unsafe bed from the	

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F 908	Continued From page 80 Resident #45, was admitted to the facility on 9/22/09. The resident's diagnoses included but were not limited to: profound intellectual disability, Down's Syndrome with severe congenital hear disease, pulmonic stenosis, polycythemia secondary to chronic hypoxemia, chronic hypothyroidism, osteoporosis, Hepatitis B carrier, and self injurious behavior. Resident #45's most recent MDS (Minimum Data Set) (an assessment tool) with an ARD (assessment reference date) of 12/5/18 was coded as a quarterly assessment. Resident #45 was coded as having severe cognitive impairment. The resident was also coded as requiring limited assistance of two staff members for transfers, and being totally dependent on staff for dressing, toileting and bathing. Resident #45 required supervision of one staff member for eating. On 03/28/19 at 10:29 AM, the bed controller for Resident #45's bed was observed with three areas where the wire coating was absent, and wires were exposed and accessible to the resident. CNA (certified nursing assistant) I, was in the room and came over to look. When asked if she saw anything wrong she pointed to the wires and said "the wires are showing, the patient can get shocked, we are going to call someone and let them know so they can replace it. They probably just didn't notice it this morning." Employee I then unplugged bed. The Administrator and DON were informed of the facilities failure to ensure equipment is in a safe operating condition on 3/28/19 during end of day meeting at approximately 3:20pm.	F 908	electrical outlet. The CNA Team Leader will inform the shift supervisor or charge nurse of any beds with open electrical wiring. The charge nurse or supervisor will immediately submit a STAT emergency work order for repair. 4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.** The Central Medical Equipment Supply Manager will do weekly checks to ensure safe working condition of all electrical beds. A log will be kept of the weekly checks and the results will be submitted to the monthly QAPI meeting for any further recommendations to ensure compliance. 5. **Include dates when the corrective action will be completed. (The "outside" date by which all corrections must be made is the 45th calendar day after the survey ended.)** The "outside" date by which all corrections will be made is the May 4, 2019.	

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F 908	Continued From page 81 No further information was provided.	F 908		